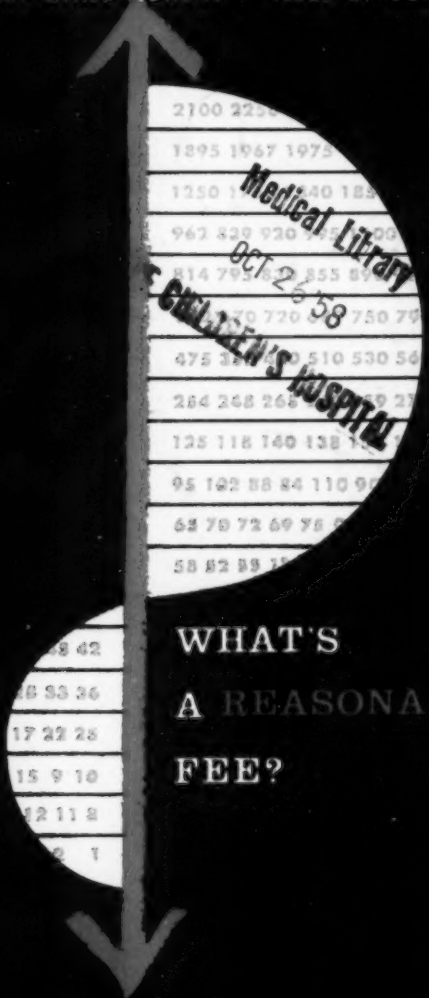


Medical Economics

PUBLISHED EVERY OTHER MONDAY • ISSUE OF OCTOBER 27, 1958



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1. Eichner, E., Goler, C. G., Sharzer, S., and Horowitz, B.: *Obst. & Gynec.* 6:511, 1955. 2. Greenblatt, R. B., and Brown, N. H.: *Am. J. Obst. & Gynec.* 63:1361, 1952.

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Medical Economics

NEWS BRIEFS

TWO INSURANCE COMPANIES HAVE SUED the Neshoba County (Miss.) Hospital for allegedly padding insured patients' bills. The first carrier won some \$6,000 in refunds. Now a second is asking the same judge to award it \$10,500 on the same charge.

IF PATIENTS IGNORE YOUR ORDERS, this may be why: Minnesota University researchers find most people forget instantly about 50% of what they hear.

FULL-TIME PSYCHIATRIC TRAINING WITH PAY of up to \$12,000 is now open to G.P.s with 4 or more years' practice who wish to become psychiatrists. It's sponsored by the National Institute of Mental Health. Doctors who don't want accreditation can get free post-graduate psychiatric courses.

TRAVEL THROUGH EUROPE WILL BE EASIER NEXT YEAR. 13 European railroads will jointly issue a "single-ticket" pass, good for 2 months' unlimited first-class passage in 14 countries. Cost: \$125.

NEWS BRIEFS

ARE TODAY'S STOCK PRICES AS INFLATED AS 1929'S?

One way to tell, says Market Analyst Ralph Rotnem, is to compare what it took to buy \$100 worth of dividends then and now. In '29, he points out, it took \$3,135; today it takes only about \$2,860.

M.D.s SHOULD START PLANNING NOW to set up one nation-wide, professionally managed pension plan in case the Keogh tax bill passes, says Dr. Kenneth Callister of Salt Lake City: "Otherwise many smaller plans will spring up, giving doctors a lower return on their tax savings."

DESPITE VEHEMENT OPPOSITION FROM SPECIALISTS, Michigan's doctors voted this month to continue selling a new Blue Shield contract with a \$7,500-per-person income ceiling. The ceiling had been hiked from \$5,000 per family to meet demands of the United Auto Workers. Since 50% of the plan's subscribers are U.A.W. members, plan officials feared any curtailment would kill the plan.

THE KAISER PANEL PLAN is seeking more hospital beds "to make room for 300,000 would-be subscribers." To help guide this expansion, the California plan this month hired a crack hospital administrator, Col. Robert L. Black. Black's most recent job: administrator of the United Mine Workers' key hospital in Harlan, Ky.

RADIOACTIVITY ISN'T SUCH A HOT TOPIC AFTER ALL, a Michigan University study indicates. Of some 2,000 people surveyed, 700 had never heard of it.

"I'M ALLERGIC TO PENICILLIN," the preoperative patient told the externe. But the word wasn't passed on to the resident who did the surgery. He ordered postoperative penicillin for the patient; the patient had an acute reaction and later sued. Who was liable? The chief of the surgical service, who was absent during the entire procedure, but who had given the resident permission to operate. The judgment: \$75,000.

CHIROPRACTORS DON'T LIKE HULA HOOPS. Connecticut Chiropractor Association's president, John S. Gray, gave one a spin, promptly warned they may give adults "spinal disadjustments . . . and backaches."

FIGHT BETWEEN CITY AND UPSTATE M.D.s over rival Blue Shield plans led the Wisconsin State Medical Society's president, Dr. Jerome W. Fons, to resign during a stormy special session of the House of Delegates. He quit when the delegates (who sponsor Wisconsin Physicians Service) voted that unless another Blue Shield plan run by Milwaukee doctors stops competing state-wide with W.P.S., the Milwaukee County society's charter will be revoked. Dr. Fons is from Milwaukee.

NEWS BRIEFS

DOCTORS HAVE PETITIONED THE LEGISLATURE to check Michigan's current polio outbreak by providing free vaccine for all who can't pay. Hard-hit Detroit has had 523 polio cases this year, compared with only 170 during a like period in 1957.

ATTORNEY MELVIN BELLI, undaunted by one set-back, recently filed his third suit against a tobacco firm whose products he claims gave a smoker cancer. Belli's first such suit was declared a mistrial after a prospective juror told the judge he'd been asked about his smoking habits.

TO TEST LABOR LEADERS' CLAIMS that they've tried (and failed) to get doctors' abuses corrected by local medical societies, Dr. George Gleason recently asked the secretaries of 23 western Pennsylvania societies: Has your grievance committee ever received any complaints from the local United Mine Workers Fund officials? His finding: Complaints have been filed in only 3 counties.

TV's WHITE-COATED HUCKSTERS ARE VANISHING, but Madison Avenue is now angling for an even better substitute. Three young M.D.s recently told the New York County medical society they'd been asked to endorse products on TV. The society warned against it, urging them to "make their effort in the practice of medicine and not in advertising."



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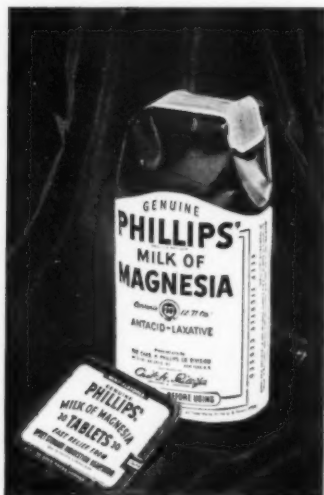
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Medical Economics

INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, OCT. 27, 1958

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Now you can write off the cost of your medical equipment faster than ever. This article tells how and when to do it

***How Solo Doctors Divide Up Office Work*73**

How much work do you delegate to your aide or aides? Here's what your colleagues do—and why you should know what they do—for your own legal protection

***A One-Eyed Look at Malpractice*78**

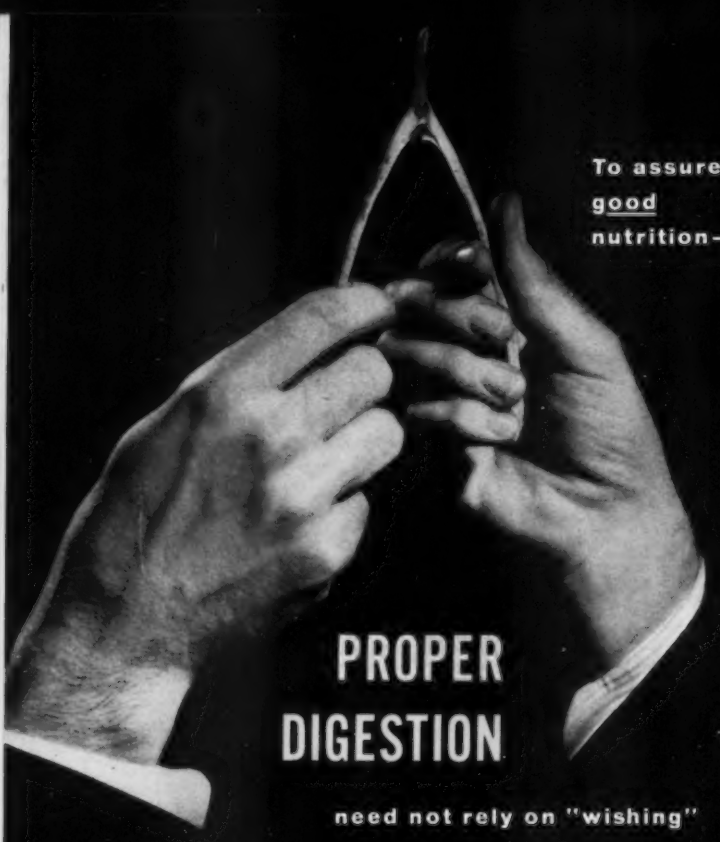
As a service to medicine, these doctors asked a psychologist to study some reasons for malpractice suits. But the service became a disservice when his report made headlines

***Start Planning Next Year's Income!*87**

How much more will you need to cover higher office expenses? Where will it come from? Decide now

—MORE ►

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Do YOU Need a Psychiatrist? 89

These doctors did—not for themselves but for their patients. They've learned how a psychiatrist can prosper and provide all sorts of help even in a fairly small community

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You have your ideas, but courts of law may have others. Here are the four criteria on which they're likely to base decisions when you sue patients for nonpayment of fees

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Want to put your sisters and your cousins and your aunts on the payroll? Go ahead. But before you deduct their salaries, better make sure you can justify the claim. Here's how

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In one state, the typical M.D. gives away \$5,360 annually—part of it in charity medical care and part in cash

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When you're rushed, the right kind of explanation from your aide can help bring patients back at a less busy time

One Way to Cope With Nonmedical 'Specialists' 131

The ophthalmologists are now fighting the 'pretensions' of optometry by means of their two-year-old National Medical Foundation for Eye Care. Here's how the battle is going

MORE ►



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That M.D. accused of negligence didn't exactly hide the facts from his defense team. He didn't exactly reveal them, either. As a result, it was a cinch for the plaintiff's lawyer

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Health issues loomed large when a dentist decided to run for Congress. His major campaign pledge: 'I'll investigate the American Medical and Dental Associations'

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Doctors are encountering fewer headaches than expected in reporting on patients applying for disability benefits

What You Can Expect From Medicare 164

The new curbs on civilian care of military dependents will mean fewer Medicare patients for some doctors. But the drop-off may be less than you'd expect. And doctors themselves helped make the restrictions necessary. You'll see why in this exclusive interview with Dr. Frank B. Berry, Assistant Secretary of Defense (Health and Medical), and Col. Floyd L. Wergeland, Medicare's executive director

Why Doctors Leave Group Practice 177

This poll of men who've quit groups suggests that too many big organizations are likely to be afflicted with 'commercialism, factionalism, favoritism, and know-nothingism'

MORE ►



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of 871 patients treated with Serpasil for hypertension *with anxiety-tension* had excellent or good overall response, while 80 per cent of 261 patients treated for tachycardia had good or excellent response.

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miscellaneous infections

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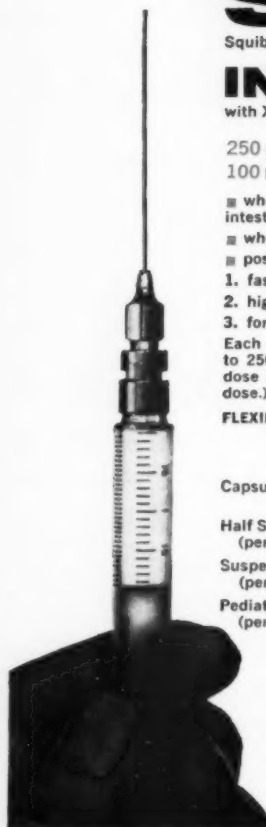
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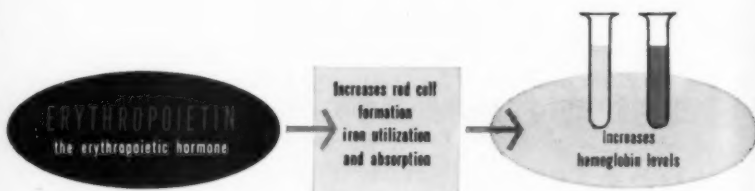
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man • 180, Dave Harbaugh.

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Letters

May Hospitals Be Choosy?

SIRS: Dr. Carl Bearse thinks it's too bad that hospitals disregard the free-choice principle by not granting courtesy staff privileges to all local practitioners. But to do so is just impracticable. Actually, if a patient's family doctor isn't a staff member of a particular hospital, this doesn't really take away the patient's free choice of physician, but only his free choice of hospital.

And why shouldn't private hospitals, like private physicians and patients everywhere, have *their* privilege of free choice?

John G. Monyak, M.D.
Aliquippa, Pa.

How to Figure Fees

SIRS: In stating his case against a national relative value scale, Dr. Arnoldus Goudsmit says we should be paid "not merely on the basis of what we do, but also of what we know." But we must face reality: The patient is interested in results, not in how many degrees and honors the physician has acquired.

Instead of a relative value scale, Dr. Goudsmit recommends the

adoption of an hourly fee schedule. In other words, he believes we should charge according to the time a procedure takes instead of according to its value in relation to other procedures. If we followed his advice, what would prevent a man from taking four hours to do a thirty-minute procedure?

M.D., Indiana

Charging for Phone Advice

SIRS: In "Don't Charge for Telephone Consultations!" Millard K. Mills says a "certain amount" of free phone advice is expected in every profession and business. True—but *only* a certain amount. Is there any sort of professional man or businessman you can call *constantly* for free advice? A lawyer, perhaps? Or an electrician?

Mr. Mills also states that few calls are needless. If a person is concerned enough to phone you, he maintains, there's need for some kind of reassurance. Well, if repeated reassurance is needed for very minor things, a dollar is little enough to pay for the privilege.

Finally, Mr. Mills points out that fees for telephone advice are

Letters

hard to collect. Who cares? The idea here isn't to make money, but to make the doctor's life more bearable.

No one minds being called on necessary, major matters. The whole idea of charging for phone consultations is to discourage the unnecessary calls. And it's a sound idea. As the man who wrote "Charge for Telephone Consultations?" not long ago in MEDICAL ECONOMICS, I've found the proof of

the pudding in the eating. Judicious charging has changed my office from a phone-jangling madhouse to a relatively serene workshop.

George Widdicombe, M.D.
Portland, Me.

What M.D.-Shortage?

SIRS: I'm fed up with hearing about the "shortage" of doctors. I graduated from a recognized state medical school, interned in the Navy, then took two years of residency. I'm a family man and neither ugly nor unpleasant—unless provoked. Yet I've unsuccessfully tried to practice in Missis-

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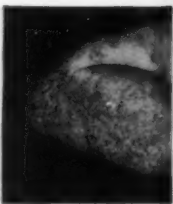
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1. Johnston, T. G., and Casort, A. G.: Clin. Rev. 1:117, 1956.
2. Warter, P. J.: J. M. Soc. New Jersey 54:7, 1957.
3. Individual Case Reports to Medical Dept., Pfizer Laboratories.
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5. Strub, I. H.: To be published.
6. Fox, J. L.: Paper presented at 14th Annual Congress, Am. Coll. Allergists, Apr. 24, 1958, Atlantic City, N. J., Ann. Allergy, to be published.



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Claude K. Smith Jr., M.D.
Monroe, La.

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SIRS: Yours is a splendid magazine for lawyers as well as doctors. Much of your financial and business information can easily be adapted to lawyers' needs.

Your legal articles are accurate and, I'm sure, very helpful. "How to Pick a Lawyer" is the best

Letters

article I've read on the subject. I would add only one further pointer to it: Pick a lawyer who'll readily admit there are some legal matters he knows little about. He's the man who will make a proper referral, when necessary.

Mark F. Joseff, LL.B.
Downey, Calif.

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Letters

tially from them. For a profession that instituted the concept of preventive medicine, you're doing much to create an awareness of preventive law.

John E. Berry
Executive Secretary,
New York State Bar Assn.
Albany, N. Y.

What's Good Medicine?

SIRS: One of your correspondents, Internist Henry B. Blumberg, says he sees little hope for the future of internal medicine because the lay public hasn't got sufficient respect for the "educated mind."

But the future of internal medicine can't be separated from the future of *all* medical practice. The biggest threat to that future lies in the "educated minds" of those medical eggheads who'd take it on themselves to decide for all of us what constitutes good medicine.

J. L. Bordenave, M.D.
Geneva, Ill.

Your Car and Your Wife

SIRS: In "Tax Savings on Your Automobile," Author M. J. Goldberg gives this advice: "When you buy a new auto, use it exclusively in your practice... After two or

three years, you can turn it over to your wife for family use. You can then turn in *her* old car for a new professional one." Mr. Goldberg may be a tax expert, but he must also be a bachelor.

If not, and if he manages to get his wife to drive the old wreck while he flashes around in the new car, what we other poor guys want to know is: How in the world does he do it?

W. I. Southerland, M.D.
Sherman, Tex.

M. J. Goldberg, a married man and father of four, acknowledges that he ducks Dr. Southerland's problem by owning one car.—ED.

M.D.-Adoption Agencies

SIRS: You quote Dr. Louis A. Trippe of Buffalo, N.Y., as in favor of permitting medical societies to set up adoption agencies. But any child-welfare agency can tell you how unhappy and scandal-ridden the adoption situation has been wherever the doctors have handled it.

Besides, many of our medical societies already have malpractice agencies, Blue Shield control, bill-collecting agencies, etc. Do we really want them to expand into the adoption field as well?

M.D., New Jersey
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full dose of iodide

treatment for every phase of the cough

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 Dihydrocodeinone Bitartrate, 10 mg. (¼ gr.)
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® Nembutal—Pentobarbital, Abbott

Abbott



Mrs. H. T., a 30-year-old housewife, bore her first child at 26 years of age. After the delivery—and now for full four years—she has been unable to shed the excess pounds gained during pregnancy. Complete amenorrhea persisted for a year after birth, followed by only gradual return to more normal menses. Despite a seemingly healthy appearance, Mrs. H. T. suffers from exhaustion. Her memory is poor; she is not alert. Since the baby's birth, she has not regained her complete strength. "I feel cold all the time," she complains. "My skin and hair are dry."

PBI is 2.0 mcg.%; BMR -33; cholesterol 385 mg.%; EKG of reduced amplitude.

Based on history and findings, a diagnosis of hypothyroidism is made and thyroid substitution (3 gr. Proloid daily) prescribed. Within 4 months, her PBI rose to 5.4 mcg.%; cholesterol fell to 242; EKG returned to normal. In view of the favorable results, therapy is continued indefinitely.

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PROLOID is available in 5 tablet sizes: $\frac{1}{4}$, $\frac{1}{2}$, 1, $1\frac{1}{2}$ and 5 grain tablets—and Proloid Powder for compounding.

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QUIACTIN provides greater tranquility, yet avoids the drowsiness that causes patient discomfort or oversteps the bounds of safety.¹ Work, and other normal activities, continue with no drop in efficiency.² Structurally, QUIACTIN is a glycidamide... atom by atom, a completely new tranquilizer, prolonged in activity, non-toxic, noncumulative and free of withdrawal symptoms. QUIACTIN will not deepen depression if it is present.

1. Proctor, R. C., Southern Psychiatric Assoc. Meeting, October 7, 1957. 2. Feuss, C. D. and Gragg, L. Jr.: Dis. Nerv. Sys. 18:29; 1957.

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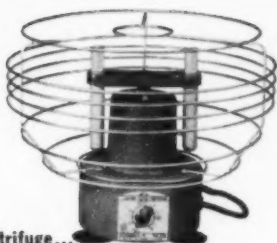
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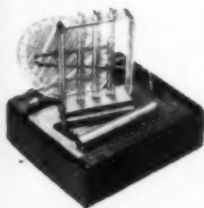
Includes all materials necessary for taking cytology samples and mailing them to laboratories. (4 doz. Ayre's "Cell Biopsy" Scrapers, 2 Vaginal Pipettes, Aspirator Bulb, 1/2 gross Rite-on slides, 2 doz. 2-slide mailers and envelopes, directions.) Complete, **\$8.00**



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Serpasil slows heart rate in most cases of organic or functional tachycardia.

You'll find it especially valuable in cardiac patients whose conditions are aggravated by heart speed-up. Through a unique heart-slowing action, independent of its antihypertensive effect, Serpasil prolongs diastole and allows more time for the myocardium to rest. Blood flow and cardiac efficiency are thereby enhanced.

What's more, you can prescribe Serpasil with confidence. Therapy with Serpasil is virtually free of the dangers (heart block and cardiac arrest) heretofore encountered with heart-slowing drugs. Side effects are generally mild and can be overcome by adjusting dosage.

DOSAGE FOR TACHYCARDIA
Dose range is 0.1 to 0.5 mg. (two 0.25-mg. tablets) per day conveniently taken in a single dose. Rapid heart rate usually will be relieved within 1 to 2 weeks, at which time the daily dose should be reduced. Suppression of tachycardia often persists after therapy is stopped.

NOTE: In patients receiving digitalis or quinidine, Serpasil therapy should be initiated with especially careful observation. Serpasil is not recommended in cases of aortic insufficiency.

SUPPLIED: Tablets, 1 mg. (scored), 0.25 mg. (scored) and 0.1 mg. Elixirs, 1 mg. and 0.2 mg. Serpasil per 4-ml. teaspoon.

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MORRIS PLAINS, N. J.

News

One State's Doctors Assess Their Relative Value Scale

The theoretical arguments for a relative value scale can at last be supplemented by experience. California's scale has been in use for more than a year, and local doctors are now able to sit back and appraise its value as an aid to fee setting. Their consensus: It's wonderful.

The Californians didn't foresee its "enormous impact," comments Dr. C. P. Callaway of the California Medical Association's Committee on Fees. He characterizes the state-wide relative value scale as "the most potent in-



Callaway

fluence on fee schedules and fees ever achieved by any group within organized medicine." In particular, he reports that the scale is rapidly being adopted by almost every kind of group concerned with medical fees—Federal and state agencies,

the courts, private insurers, labor unions, the Blue plans.

"Deceitful fee schedules . . . have been exposed as unfair," Dr. Callaway goes on. "For the first time, whenever the profession has been forced into the negotiation of fees, our representatives have enjoyed the advantages of actuarially sound statistics in describing our needs."

California's scale is based on a 1954 survey of fees charged by California's doctors. Now the state medical society is planning a new survey. It wants to work out a new scale that reflects medical fees in 1958.

Are Medical Authors Helping Malpractice Lawyers?

An alert malpractice attorney can find "a ready-made and heaven-sent weapon" for use against defendant doctors just by leafing through medical journals, observes a recent editorial in the Virginia Medical Monthly. All the attorney has to do is look for "the not infrequent statement by a medical writer that if such and such a situa-

Most surgical procedures used in gastric operations today stem from the partial gastrectomies and gastro-enterostomies originated by

Theodor B. Billroth

(1829-1894) and his assistant Anton Woelfler.

Billroth I and II are bywords in gastroenterological surgery.



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**Miltown + anticholinergic*

tablet t.i.d. with meals

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control G.I. pain, spasm,

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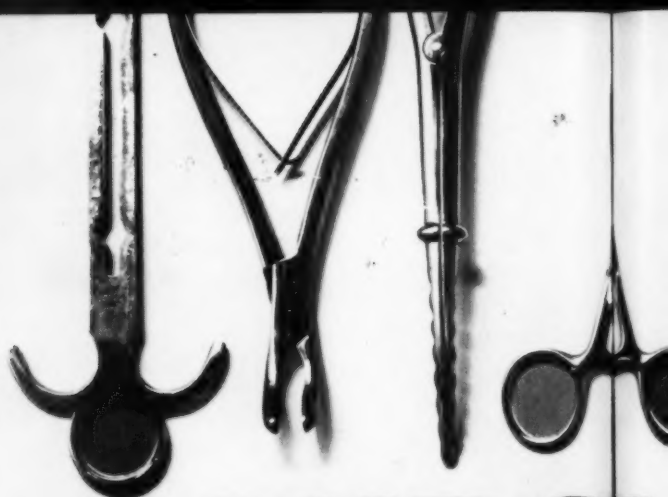
Indications: duodenal and gastric ulcer • colitis
spastic and irritable colon • gastric hypermotility • gastritis
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diarrhea • G. I. symptoms of anxiety states.

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tion arises, the physician who does not do so and so is 'guilty of malpractice.'

"It is easy to understand how an author may be . . . carried away by the intensity of his enthusiasm when writing about his favorite topic," the editorial continues. "Dangerous statements of this type should, however, be blue-penciled before they appear in print . . .

"Those authors who favor the Virginia Medical Monthly with their manuscripts are earnestly requested to omit from their articles any reference to malpractice."

One in Three Now Gets Fluoridated Water

The latest progress report on fluoridation shows that despite all the furor, fluoridated water is now drunk by some forty million Americans. That's one-third of the people who get their water from community systems.

Specifically, 870 water systems now add fluorides (or, in a few cases, use water that naturally contains fluorides). Only sixty-nine have discontinued fluoridation; and of these, thirteen have since reinstated it.

Of the eighteen cities with populations over 500,000, twelve provide fluoridation. They are Baltimore, Buffalo, Chicago, Cleveland, Houston, Milwaukee, Minneapolis, Philadelphia, Pittsburgh, St. Louis, San Francisco, and Washington, D. C.

Medical Meetings Abroad: Are They Tax Dodges?

Time was when a "World Congress in this, that, or the other specialty" seemed nothing more than "an excuse to travel outside the United States, with the distinct tax . . . advantage" of per-

mitting the traveling U.S. specialist to deduct many of his trip expenses. That's what Dr. Samuel A. Overstreet, a Louisville, Ky., internist, used to think about such meetings.



Overstreet

But in the last few years, he observes, international medical meetings have proved themselves to be "genuinely useful." They've made it possible for new methods of managing "infectious diseases in England, or eye surgery in India, or hepatitis in Chile" to become

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Caffeine 30 mg.

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Methamphetamine hydrochloride 1.25 mg.


Dosage—1 capsule q. 4-6.

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Children's cold symptoms
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LIKE MAGIC WITH 

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(no caffeine)

color-flecked tablets for relief from sneezes, sniffles, fever

Each MEDILET contains aspirin 80 mg., phenacetin 16 mg., chlor-
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News • News

part of American doctors' armamentarium "this week," rather than many months later. And Dr. Overstreet adds:

"There is no question but that learning is better accomplished by personal contact and free exchange of ideas firsthand than by written reports . . . The World Congress therefore becomes eminently useful and practical as a medium of exchange, and entirely in keeping with the tempo of the present generation."

Research Made Practicable For Staff Physicians

Must a hospital research program be a disorganized jumble of one-man projects? It isn't in The Children's Hospital of Columbus, Ohio. Staff doctors there are working on coordinated research projects without having to worry about bothersome details—such as where the money's coming from.

Several years ago, the hospital's research pattern typified that of many other hospitals. As Chief of Staff E. H. Baxter and Administrator Robert M. Porter remember it: "More research was under way than anybody realized [but it] was



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symbol represents
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THE ORINASE* EPOCH

Freed from the encumbrances of needle syringe and sterilization, and freed from the tensions caused by worry about potential hypoglycemic reaction, the patient on Orinase can look forward to a more normal type of life in which his metabolic disorder is not complicated by the paraphernalia of injection.

For the newly discovered patient, the diagnosis of diabetes is no longer a commitment to a long sentence of

injections. Families of diabetics can now assume a more normal way of life, unimpeded by social and economic disabilities and the personal demands of the metabolic invalid. This new era has opened for the majority of diabetics. Those most responsive have had onset of diabetes after 40 years of age and, if on insulin, generally require less than 40 units daily.

"Orinase-responsive" patients, as a group, usually enjoy a superior quality of control. With Orinase, the management of diabetes is smoother, associated with a feeling of greater stability and well-being, and free from the danger of hypoglycemic shock. Patients are more cooperative and can assume occupations from

which hormonal therapy might disqualify them.

New diabetics are easier to indoctrinate and to manage. Mild diabetics, who either personally object to insulin or whose diabetes is so mild as to make one hesitate to add insulin to the regimen, are both excellent candidates for Orinase.

It has been shown that in the presence of a functional pancreas, Orinase effects the production and utilization of *native* insulin via *normal* channels. Its administration results in changes in fat and protein metabolism known to be the physiologic resultants of insulin activity. More recently, several investigations have demonstrated that the effects of Orinase upon hepatic glucose release are none other than those of endogenously produced or endo-

portally administered insulin. These observations have been followed by the further realization that the liver may play a primary physiologic role in the mechanisms of insulin action. Experience with Orinase suggests a classification of diabetics into two apparently distinct groups—Orinase-responsive or "Orinase-positive" diabetics, and "Orinase-negative" diabetics. It remains to be determined whether these will prove to be distinct clinical entities.

vs • News • News

suffering from lack of coordination . . . and of money. In some cases no one knew much about any project except the man pursuing it."

In The Children's Hospital today, all research is administered by a semi-autonomous organization set up by the medical and dental staff. Called CHILD (for Children's Hospital Investigative Laboratories Division), the unit takes care of the details that usually plague medical researchers: lining up financial backing, providing facilities and equipment, keeping the necessary records.

The medical staff, comments Dr. Baxter, "had little talent or taste for the grubby nonsense of marking down where the dollars went." And the hospital's administrative offices were too busy to handle these tasks. So CHILD, self-supporting and self-administered, fills the bill.

Insurance Men Ask M.D.s: What Fees Do You Want?

It may come as a surprise, but the insurance industry is interested in what you and other doctors think of its health insurance plans. And that interest is being shown

by a rash of meetings between insurance men and doctors around the country.

The idea for an exchange of views came out of a conference of A.M.A. officers and insurance company presidents last year. The Health Insurance Council has followed through by arranging meetings of medical and insurance men in forty states. Main problem up for discussion: Can the insurance men write policies at premiums that give the public adequate coverage and pay the doctor adequate fees?

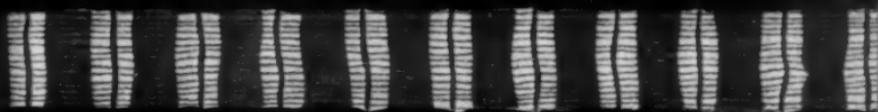
Here's the way Chairman Kenneth Barrows of the Iowa committee of the H.I.C. put the problem to doctors recently:

"The American medical bill now runs from twelve to fourteen billion dollars a year. Voluntary health insurance, commercial carriers, Blue Cross-Blue Shield, and independent plans pay about four billions, or one-third. We think we should pay two-thirds."

But advances in medicine cost money, he noted, and: "We [insurance men] are fearful of pricing ourselves out of the market."

"Only the Government can do the job more cheaply," he warned. "They can do it more cheaply only by paying less for medical services. This, we know, will down-

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PARAFON*

*for relief of pain, stiffness, and disability
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in arthritic and rheumatic disorders

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supplied: Tablets, scored, pink, bottles of 50. Each tablet contains: **PARAFLEX** Chlorzoxazone 125 mg.; and **TYLENOL** Acetaminophen 300 mg.

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adds the anti-inflammatory action of prednisolone to the relief of pain and spasm achieved with **PARAFON**. **PARAFON WITH PREDNISOLONE** is useful in many arthritic and rheumatic disorders, such as rheumatoid arthritis, rheumatism, myositis, neuritis, tenosynovitis, fibrositis, bursitis, spondylitis, and osteoarthritis.

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grade the quality of medical service.

"We don't want to fix the doctor's fees," he concluded, "but we think we could do a better job if doctors gave us some reasonable standards to go by."

Patient-Stealers? No, They Just Offer Better Service

"'Free choice of physician' has been repeatedly emphasized as the stand of all medical organizations fighting socialized medicine. Yet all too often when the patient tries to exercise this 'free choice,' he is treated by his physician as though he were guilty of treason."

That's the observation of Dr. Robert A. Major. Writing in California GP, the publication of the California Academy of General Practice, he holds there's only one way to react when a patient wants to switch to another doctor:

"Accept the decision gracefully and send him off with your good wishes . . . Anything [else] reflects unfavorably on the medical profession as a whole, as well as [on] the particular physician."

And Dr. Major has this thought for doctors who mutter that every

departing patient has been "stolen" by some colleague: "Too often all the 'thief' does is provide better service."

But handling the patient who wants to transfer to an unethical practitioner calls for a different attitude, Dr. Major advises: "Then the doctor has the right and responsibility to warn the patient and try to persuade him to visit another physician instead."

Which Accident Insurance Is Tax-Deductible?

The income tax law says "amounts paid for accident or health insurance" may be deducted as medical expenses. Any "accident or health" insurance? No, according to a recent ruling of the Tax Court; not every accident policy qualifies. Which can you deduct? Only policies that reimburse you for medical expenses arising from accidents.

The case at issue involved a taxpayer who'd deducted the \$763 in premiums he spent for accident insurance that would pay lump-sum benefits in case of accidental loss of life, sight, or limb. The Court ruled he couldn't deduct the full premium. Why? Because Congress wasn't thinking of accident coverage unrelated to medical ex-

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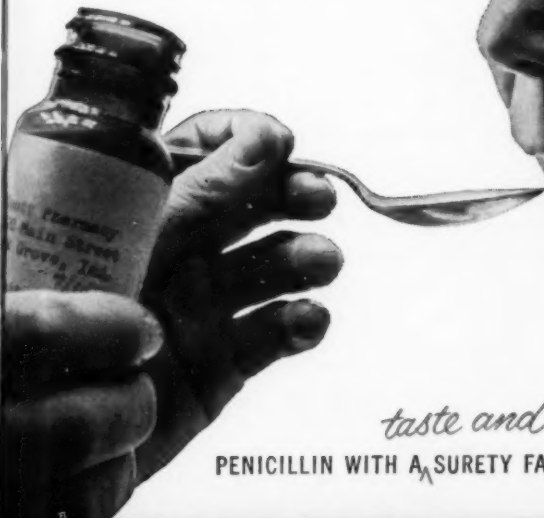
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Cherry flavor—300,000 units per 5-cc. teaspoonful, bottles of 2 fl. oz.

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FORD, R. V., Rochelle, J.B.III, Handley, C. A., Moyer, J. H. and Spurr, C. L.:
J.A.M.A. **166**:129, Jan. 11, 1958.

"... in premenstrual edema, convenience of therapy points to the selection of chlorothiazide, since it is both potent and free from adverse electrolyte actions." In the vast majority of patients, 'DIURIL' relieves or prevents the fluid "build-up" of the premenstrual syndrome. The onset of relief often occurs within two hours following convenient, oral, once-a-day dosage. 'DIURIL' is well tolerated, does not interfere with hormonal balance and is continuously effective—even on continued daily administration.

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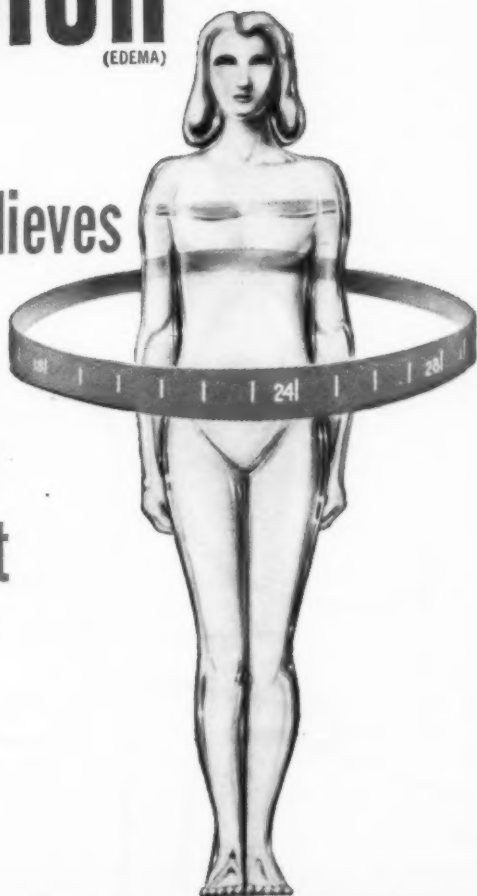
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Distress

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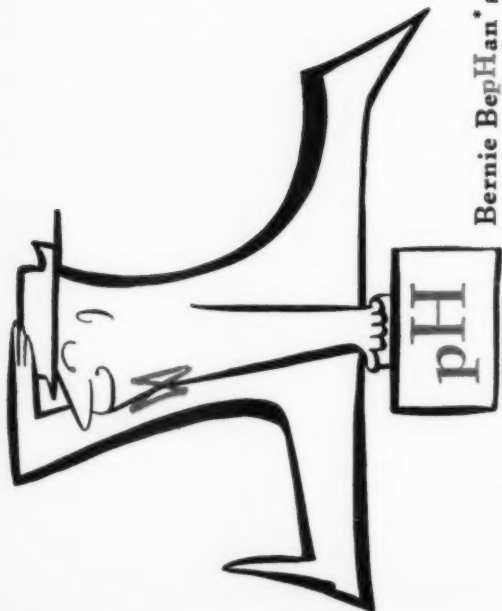


ANY INDICATION FOR DIURESIS IS AN INDICATION FOR 'DIURIL'

MEDICAL ECONOMICS • OCTOBER 27, 1958 47



Supplement
Page 42



Bernie BepHan* says,

BepHan Spacetabs® for *fast* and *sustained* antispasmodic-antacid action — stops heartburn, gastritis, ulcer-pain syndrome, heartburn of pregnancy, etc.

Day-long/night-long protection with convenient dosage: just one BepHan Spacetab, chewed morning and evening.

Each contains: Bellafoline® 0.5 mg., Aluminum hydroxide + Glycine 450 mg., Magnesium Oxide 60 mg.

*T. M. Applied for



penses when it wrote the deduction provisions of the law.

But the same decision did point up a small saving that you might easily overlook in filing your return. The Court allowed the taxpayer to deduct \$40 of the \$763 he had claimed. Reason: His insurance provides some coverage for medical expenses. He was granted a deduction for this medical-coverage portion of his premium. It's a point to remember if you have any policy with a subordinate provision for medical benefits.

'Best Place to Live' Has Highest Suicide Rate

If you listen to doctors and other travelers, San Francisco is the city almost everyone would like to move to. But the people who've moved there already are causing concern among San Francisco doctors. Apparently the state of their mental health is the opposite of what you'd expect.

"Our city [now has] the highest suicide rate in the United States," reports Dr. Edgar Wayburn, editor of the San Francisco Medical Society Bulletin. "It has the highest percentage of alcoholism . . . Mental and emotional disease have become currently our most common

News • News • N

and expensive illnesses. And [we're] poorly equipped" to provide all the care that's needed.

In the face of this "critical mental-health problem," San Francisco doctors are mobilizing for action. Already they've played a key role in getting California to pass a new law. It makes state money available

to communities that are willing to spend money of their own on improving mental-health services.



Wayburn

How will San Francisco use its new funds? The first need, the doctors say, is to

relieve overcrowded psychiatric wards. According to the medical society's Mental Health Committee, "the population of these wards should be reduced from 30 per cent to 50 per cent." The Committee's key recommendation: Find space and personnel elsewhere for alcoholics.

After that, according to Dr. Wayburn, the next goal is to promote "local, short-term psychiatric" treatment, instead of the all-too-

s • News • News

prevalent prolonged isolation in remotely located state hospitals.

"Implementation of the [society's] recommendations . . . has already begun," Dr. Wayburn adds.

Hospital Makes M.D.s Pay For Incomplete Records

Hospital medical directors have tried pleas, cajolery, and threats to get house-staff physicians to complete their medical records on time. Now Dr. Roberto J. Jimenez, medical director at Presbyterian Hospital in San Juan, Puerto Rico, has come up with a drastic remedy. If it catches on, his name will probably be cursed by generations of fledgling doctors. Excerpts from the new regulations he's published at his hospital:

"Records on patients discharged by 12 noon Friday will be completed by 8 A.M. of the following Monday. Failure to comply with this requisite will result in one or all of the following three administrative punitive consequences:

"1. Internes will remain in the hospital during the week-end, whether 'off duty' or 'on duty,' to accomplish this assignment.

"2. Any record that is not com-

pleted by the above deadline will be lost to the interne. Those records will be assigned for completion . . . to [other] residents and internes . . . For every record uncompleted by the interne, \$1 will be deducted from his monthly allowance, and this amount will be given to the resident or interne who completes the record . . .

"3. Any interne having more than forty records uncompleted by the end of any month, these records having required assignment to others for completion, will not receive credit in the department assigned. He will be required to repeat the month in that department at the termination of his internship year. No monetary monthly allowance will be authorized for time being made up . . ."

Would this get-tough program work in other hospitals where staff M.D.s are laggard with their records? Dr. Jimenez thinks so. Results in his hospital, he says, are "magnificent."

Z for Scratch Tests

The mark of Zorro is now the mark of a California pediatrician. Here's how he capitalizes on the popularity of TV's black-caped, sword-wielding hero among the small fry: When the kids come in for

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ACHROCIDIN

TETRACYCLINE-ANTIHISTAMINE-ANALGESIC COMPOUND LEDERLE

A versatile, well-balanced formula for treating common upper respiratory infections, particularly during respiratory epidemics; when bacterial complications are observed or are likely; when patient's history is positive for recurrent otitic, pulmonary, nephritic, or rheumatic involvement.

CHECKS SYMPTOMS: Includes traditional components for rapid relief of the traditional nonspecific nasopharyngitis, symptoms of malaise, chilly sensations, inconstant low-grade fever, headache, muscular pain, pharyngeal and nasal discharge.

Available on prescription only.

Adult dosage for ACHROCIDIN Tablets and new caffeine-free ACHROCIDIN Syrup is two tablets or teaspoonfuls of syrup three or four times daily. Dosage for children according to weight and age.

TABLETS (sugar coated)

Each Tablet contains:

ACHROMYCIN® Tetracycline	125 mg.
Phenacetin	120 mg.
Caffeine	30 mg.
Salicylamide	150 mg.
Chlorothen Citrate	25 mg.

Bottles of 24 and 100.

SYRUP (lemon-lime flavored)

Each teaspoonful (5 cc.) contains:

ACHROMYCIN® Tetracycline equivalent to tetracycline HCl	125 mg.
Phenacetin	120 mg.
Salicylamide	150 mg.
Ascorbic Acid (C)	25 mg.
Pyrimidine Maleate	15 mg.
Methylparaben	4 mg.
Propylparaben	1 mg.

Bottle of 4 oz.

- adenitis
- sinusitis
- otitis
- bronchitis
- pneumonitis

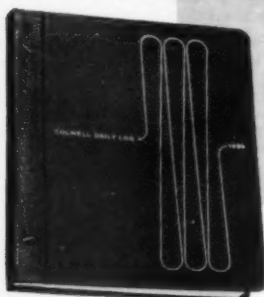
prevents the multifarious sequelae



LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York
*Reg. U.S. Pat. Off.

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FOR NEXT YEAR'S SCHEDULING



Colwell's 1959 DAILY LOG

PREFERRED by thousands of physicians since 1927. A thoroughly organized and up-to-date financial record system designed specifically for the medical profession.

GIVES FACTS for management — for tax returns. Professional and personal figures kept separate. No bookkeeping knowledge required — SIMPLE and EASY to use.

FULLY DATED with month, date and day printed on each Daily Page.

LOOSELEAF FORMS bound in dated, attractively embossed screw-post binder. Handsome 7-ring flat-opening binder also available to hold forms from "post-bound" editions. Return forms to original post-binder for safe, accessible storage at end of year.

PRICES: Regular Edition — one 36 line page a day, one volume, dated for calendar year 1959 — **\$7.75.** Double Log Edition — two facing pages of 36 lines for each day, two volumes, dated for calendar year 1959 — per set **\$13.50.**

Order direct or write for complete information and Free Record Supplies Catalog.

THE COLWELL COMPANY
238 University Ave., Champaign, Ill.

News • News

allergy tests, he makes the scratches in the form of Zorro's "Z." By popular demand, of course.

Doctor's Widow Wins Out Over Tax Collector

A doctor's widow, Mrs. W. M. Watkins of Louisville, Ky., has triumphed over the Internal Revenue Service in a recent Tax Court case. At issue was the large amount of cash her husband left her. The tax collector insisted it was unreported income and, consequently, wanted a bite of it for back taxes.

The Revenue Service pushed its claim by using one of its favorite techniques for determining the validity of income tax returns: the "net worth" formula. To apply it, revenue agents reconstruct a man's net worth at the beginning and end of the period under examination. They use records of bank accounts, stocks and bonds, and real estate holdings to piece together the financial picture, then compare it with the man's tax returns.

When they looked at the cash in Dr. Watkins' estate, the tax men decided his reported income for the four years preceding his death couldn't account for the accumu-

New Milprem® 200

a new potency for
greater dosage flexibility
in treating the **menopause**



SUPPLIED: Bottles of 60 tablets.

DOSAGE: One tablet t.i.d. in 21-day courses
with one week rest periods.

Should be adjusted to individual requirements.

ALSO AVAILABLE: Milprem-400 (400 mg.

Miltown + 0.4 mg. Conjugated Estrogens,
equine) in bottles of 60 tablets.

Literature and samples on request



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relief
from
emotional
and somatic
disturbances
of ovarian
decline*

s • News • News

lation of such a sum. So they sent Mrs. Watkins a bill for back taxes.

But the Tax Court ruled that this wasn't permissible. It noted that during his last years Dr. Watkins had been an ailing man with reduced earnings. The cash in question, it pointed out, was likely left over from earlier years. The Revenue Service "erred," said the court, "in failing to allow for any opening cash" at the beginning of the four-year period it challenged.

Surgeon Says Marriage Distracts Residents

Today's residents can't concentrate, because they're married and put family problems ahead of their jobs. That's the diagnosis of Dr. Bernard J. Ficarra of Oyster Bay, N. Y.

"Most residents today," he says unhappily, "... are shackled with family responsibilities which inevitably distract them, or destroy the peace of mind which enables the avid student to devote 100 per cent of his energy to the acquisition of knowledge."

Dr. Ficarra gives an example of what he has in mind. "All of us," he remarks, "have heard residents

receive messages in the operating room to call their ... wives." While not against marriage, he thinks its proper place is the home.

Car Costs Climbing? Well, Don't Get a Horse

As automobiles get more expensive, there may be times when you yearn for the simple days of the inexpensive horse and buggy. Yet the unromantic truth is that Grandfather switched to an automobile because it cost him *less*.

According to an account in the Brooklyn (N.Y.) Medical Journal, in 1906 an automobile cost about \$1,200; the standard doctor's buggy and two horses ran to \$1,250. And look at the difference in upkeep:

Horse and Buggy

Oats, hay, straw\$240
Hired man 240
Stable rent 100
Shoeing, sundries 120
Annual upkeep	<u>\$700</u>

Motor Car

Gasoline, oil\$ 70
Hired man 240
Garage rent 100
Tires, batteries, etc.	... 130
Annual upkeep	<u>\$540</u>

Having considered these figures,

WHY RISK DELAYED RECOVERY FROM

PYODERMAS?

Many of the organisms causing pyoderma are refractory to routine antibiotic therapy. If the offending organisms are resistant staphylococci, CATHOMYCIN (novobiocin) is indicated. CATHOMYCIN has an established record* of effectiveness against strains of organisms resistant to other antibiotics. It may be administered alone, or combined with other antibiotics for protection against the emergence of resistant strains.

Of particular value in hard-to-control pyodermas caused by resistant staphylococci, CATHOMYCIN is rapidly absorbed—producing therapeutic blood levels that last for 12 hours or more. The drug is generally well tolerated and there is no evidence of cross-resistance with other antibiotics.

CATHOMYCIN[®]

for staphylococcal septicemia, enteritis, postoperative wound infections and other serious staph infections.

NOVOBIOCIN

DOSAGE: Adults: CATHOMYCIN Sodium 2 capsules b.i.d. or CATHOMYCIN Calcium Syrup 4 teaspoonfuls b.i.d. Children: (up to 12 years) 2 to 8 teaspoonfuls daily in divided doses based on 10 mg. CATHOMYCIN per lb. of body weight per day.

SUPPLIED: Capsules sodium novobiocin, each containing the equivalent of 250 mg. of novobiocin—vials of 16 and 100—and as an orange-flavored syrup (aqueous suspension), in bottles of 60 cc. and 473 cc. (1 pint). Each 5 cc. CATHOMYCIN Syrup contains 125 mg. (2.5%) novobiocin, as calcium novobiocin.

*Complete bibliography available on request.



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CONVENIENT ANTACID

For patients who must
stay on the job

*Easy to Carry. Pleasant to Chew.
Fast Efficient Results.*

The formula of BiSoDoL Mints readily indicates why they afford such prompt and effective relief from heartburn and indigestion due to gastric acidity. No side effects. No constipation. No acid rebound or alkalosis. Free from sodium ion — BiSoDoL Mints help restore the normal pH of the stomach to maintain the optimum in physiological functioning. Most convenient for working patients to carry in their pocket or purse.



Composition:
Magnesium Trisilicate,
Calcium Carbonate,
Magnesium Hydroxide,
Peppermint.

WHITEHALL LABORATORIES, NEW YORK, N. Y.

56 MEDICAL ECONOMICS • OCTOBER 27, 1958

News • News

the Brooklyn Medical Journal concluded it's obvious why "physicians were the first to use motor cars in their business."

Been Offered Any Florida Land Bargains Lately?

Doctors who watched the Florida land boom and bust of the Twenties are having their memories jogged by a new wave of promotional material. Mailboxes, especially those of East Coast physicians nearing retirement age, are being filled with literature from a new generation of Florida real estate developers.

The extravagant descriptions of "waterfront wonderlands" have a familiar ring. And now, just as thirty years ago, the colorful illustrations are often visions of swimming pools, golf courses, and community centers that exist only in the artist's mind.

The National Better Business Bureau and the Florida Real Estate Commission warn recipients of such brochures not to buy "sight unseen." These warnings are underscored by a real estate authority who reports:

"If an inland tract to be pro-

This patient's blood-pressure controlled for the first time without side effects

Remember this particular patient. He typifies the thousands of patients involved in a clinical investigation which promises to bring about a major change in rauwolfia therapy. The patient is being treated in a Massachusetts hospital. His blood pressure without treatment ranged up to 220/138; now *for the first time*, it is being maintained near normal *without side effects*. This dramatic case history is part of the story of a remarkable new antihypertensive agent

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coming as soon as sufficient supplies are available...
from CIBA, world leader in hypertension research.

2/2000MK



• News • News

moted as a 'waterfront' community doesn't have water on it, canals or lakes are created—by bulldozing holes and allowing them to fill with water."

Such practices aren't followed by all developers, but by enough of them to make the wise shopper beware. If you're considering land in Florida, here are two suggestions from the Florida Land Investment Report:

1. Don't expect improved land

that's worth anything to cost less than \$1,000 for a 100' x 100' plot—and at that it would be underpriced.

2. Consider saving money by buying outside a development. Some promoters ask many times more than you'd pay for land that's available nearby.

'Rx Restraint Should Earn Doctors a Medal'

"Today . . . when an American goes to the doctor, he expects a prescription," says the Journal of

GLUKOR effective in 85% of cases.¹

Glukor may be used regardless of age

IMPOTENCE



and/or pathology . . . without side effects . . . effective in men in IMPOTENCE, premature fatigue and aging.² **GLUTEST** for women in frigidity and fatigue.³ Lit. available.

The original synergistically fortified chorionic gonadotropin. Dose 1 cc IM—Supplied 10 & 25 cc vials.

1. Gould, W. L.: *Impotence*, M. Times 84:302 Mar. '56.

2. *Personal Communications from 110 Physicians.*

3. Milhoan, A. W., *Tri-State Med. Jour.*, Apr. '58.

Reg. U. Pat. Off. Pat. Pend. © 1958

*Research
Supplies*

Pine Station, Albany, N. Y.



nasal and paranasal congestion and control secondary invaders

Now, a single unique preparation, Trisulfaminic, can provide dramatic relief from congestion, and at the same time protect the patient from secondary bacterial invaders. Often within minutes of the first dose, congestion begins to clear; the patient can breathe again.

Trisulfaminic is particularly valuable for the "almost well" patient who is recovering from influenza but is left with congested nasal and bronchial passages. And for patients with purulent rhinitis, sinusitis or tonsillitis, combination therapy with Trisulfaminic offers a most realistic approach to total treatment.

Oral Decongestant Action. Through the action of Triaminic, nasal patency

is achieved rapidly and dramatically. Adequate ventilation helps eliminate mucus-harbored pathogens. And because Trisulfaminic is administered orally, there is no problem of rebound congestion, no pathological change wrought in the nasal mucosa.

Wide-Spectrum Action. Secondary bacterial infections, which are always a threat in upper respiratory involvement, are forestalled by the wide-spectrum effectiveness of triple sulfonamides. This added antibacterial protection makes Trisulfaminic highly useful in treating the debilitated patient who is prone to lingering or frequently recurring colds.

Trisulfaminic tablets and suspension

TRIAMINIC PLUS TRIPLE SULFAS

Each Tablet and each 5 ml. teaspoonful of Suspension contains:

Triaminic®	25 mg.
(phenylpropanolamine HCl.	12.5 mg.;
pheniramine maleate	6.25 mg.;
pyrilamine maleate	6.25 mg.)
Trisulapyrimidines U.S.P.	0.5 Gm.

Dosage: Adults—2 to 4 tablets or teaspoonfuls initially, followed by 2 tablets or teaspoonfuls every 4 to 6 hours until the patient has been afebrile for 3 days. Children 8 to 12 years—2 tablets or teaspoonfuls initially, followed by 1 tablet or teaspoonful every 6 hours. Younger children—dosage in proportion.

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska • Peterborough, Canada

**DOCTORS AVERAGE 25%
NET RETURN ON THIS
INVESTMENT OPPORTUNITY!**



Many doctors and dentists today own coin-operated unattended Westinghouse Laundromat® equipped laundry stores all over America. This proved investment opportunity nets them \$4000-\$8000 annually in their spare time.

Briefly, Here's What It Is:

1. A coin-operated laundry store virtually runs itself because all equipment is coin-metered and easily operated by customers. No attendants are necessary. Maintenance work is done by a neighborhood porter.
2. Many stores operate 24 hours a day, 7 days a week, thereby accumulating profits during night and weekend hours when other laundry stores are closed.

Here's What It Does For You:

1. Because it requires only a few hours of management time weekly, it does not interfere with the demands of your profession.
2. Accelerated depreciation schedules permit rapid accrual of equity... offer attractive tax deductions.

We have planned over 7000 successful laundry stores throughout the country... have the know-how essential to the security of your investment. You will receive assistance, complete training and promotional help from the national organization that originated and pioneered the coin-operated laundry store. We finance up to 80% of the necessary equipment. For full details, fill out the quick-action coupon below.

ALD, Inc.
7045 N. Western Ave., Dept. M.
Chicago 45, Ill.

I'd like to hear more about WESTINGHOUSE LAUNDROMAT® equipped coin-operated laundry stores. Please have your representative contact me.

Name

Address

City State

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News • News

the Iowa State Medical Society. If he doesn't get it, he's disappointed or even angry. So "more and more doctors" are prescribing "more and more medicine."

Physicians who have the courage to buck the trend should be honored for it, the Journal asserts. "We should honor the brave doctor who does not prescribe antibiotics for every cold... who does not give shots to every patient who complains of fatigue." In fact, says the Journal, "the A.M.A. ought to give a medal occasionally to doctors who refuse to order medicines for some of their patients!"

Hospital Doctors Object to Wrong Kind of Neighbors

The new next-door neighbors are nice and quiet—but staff doctors at the Cone Memorial Hospital in Greensboro, N. C., are unhappy just the same. There are some kinds of enterprises, they told the City Council, that shouldn't be allowed to locate within 200 feet of a hospital.

The Council overrode their protest. It went right ahead and granted a building permit to the Forbis and Dick Funeral Home. END

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HELPS MEET THE NUTRITIONAL CHALLENGE OF PREGNANCY



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(Prenatal Dietary Supplements, Lilly)

dietary fortification along
modern concepts of nutrition

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High-concentration topical salicylate-menthol therapy (BEN-GAY) offers safe, penetrating relief of painful joints and muscles resulting from overexertion.

New, objective evidence:

A double-blind study¹ has reaffirmed the exceptional efficacy and safety of conservative, local treatment of chronic rheumatic disorders with BEN-GAY® (BAUME BENGUÉ), a high-concentration salicylate-menthol compound.

The local and systemic effects of BEN-GAY were evaluated by entirely objective methods in 211 subjects of both sexes suffering from various types of chronic arthritis, bursitis, neuralgia, myalgia and lumbago. Changes in range of joint motion were determined by goniometer and by flexion. Topical application of BEN-GAY measurably improved articular function in 94% when physical therapy was also used, and in 61% without adjunctive treatment. Efficient absorption of salicylate through the skin was indicated by an average urinary excretion of 15 mg. in 24 hours. No ill effects were reported or observed.

Benefits of Topical Salicylate in chronic rheumatic disease

Menthol-induced hyperemia plus high local concentration of salicylate has been recently rediscovered as one of the safest and most promptly effective remedies for rheumatoid discomfort due to exposure.



This controlled study offers new evidence of the efficacy and safety of local treatment of chronic rheumatic disease with BEN-GAY, one of the safest and most reliable formulae at the physician's disposal. BEN-GAY is available in two strengths, *Regular* and *Children's*. THOS. LEEMING & CO., INC., 155 East 44th St., New York 17, N.Y.

¹Brusch, C.A., et al.: Md. State Med. J.; 5:36, 1956.

More efficient salicylate penetration of treated area and quicker relief of pain is now made possible by water-washable, new GREASELESS-STAINLESS BEN-GAY.



for the man who "can't go on" after 4:30

Many of your patients probably suffer from brief spells of dejection. Frequently these "letdowns" appear at the same time each day: at 4:30 in the afternoon to the man in his office and at 8:30 in the morning to his wife, after she's seen her husband and children off to work and school.

Dexamyl*—the unique "normalizer"—offers the balanced actions of Dexedrine* (dextro-amphetamine sulfate, S.K.F.) and amobarbital to help your patients "weather" these brief episodes of discouragement. Dexamyl's effect is one of gentle mood amelioration, uncomplicated by after effects. Available as tablets, elixir and Spansule* sustained release capsules.

Smith Kline & French Laboratories, Philadelphia



*T.M. Reg. U.S. Pat. Off.



X 125,000. Electron micrograph (courtesy of RCA.)

the clue is in the crystals—

more than 5 times as adsorptive as kaolin

... crystals of Claysorb*, showing the tremendous surface area for adsorption. Because of Claysorb and its great adsorptive property, POLYMAGMA Plain rapidly removes intestinal bacterial toxins and irritants. Refreshing to the taste, POLYMAGMA Plain also soothes and protects the irritated mucosa; acts quickly on a low-dose regimen to restore normal intestinal function. (For infectious diarrhea, POLYMAGMA—same formula plus dihydrostreptomycin sulfate and polymyxin B sulfate.)

Supplied: Bottles of 12 fl. oz.



This advertisement conforms to the Code for Advertising of the Physicians' Council for Information on Drug Abuse.

NEW, MORE EFFECTIVE ANTIDIARRHEAL



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Polymagma[®] Plain

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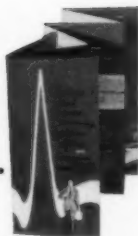
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ANSWERING DOCTORS' QUESTIONS . . .

about the **SANBORN** Model 300 Visette electrocardiograph



The text and pictures in this new 12-page booklet tell the story of the Sanborn Visette ECG in a unique way: as *answers to actual questions asked by hundreds of doctors* — at medical conventions, in correspondence, in conversations with Sanborn people. Many of these questions are probably ones you might also ask, to get a clear picture of just how a Visette might fit into *your own* practice and diagnostic procedures. Here are facts *you* can use, presented from the *doctor's* point of view.

On simplicity and ease of Visette operation, for example, the booklet pictures and describes such features as *automatic stylus stabilization*, as leads are switched; *push-button* grounding; *automatic shut-off* when the cover is closed; *quick, jam-proof* paper loading, in seconds. And

graphic proof of *true portability* — that allows you to take a Visette on any call — is dramatically illustrated by the Visette's 18 pound weight and "brief case" size. Your nurse or technician can carry a Visette as easily as a portable typewriter, and this modern 'cardiograph takes the same space on her desk as a letterhead!

Your colleagues' questions — answered by those who designed and built this first truly portable ECG — can have special value to you. Send for your copy of this useful booklet now. And when you would like a Visette demonstration in your own office, or details of the no-obligation, 15-day Trial Plan, call the Sanborn representative in your area.

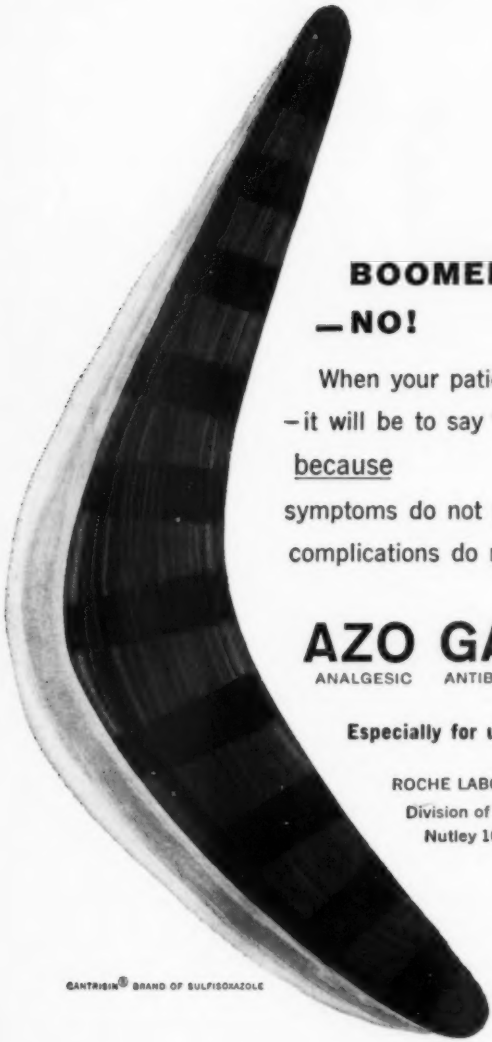
The familiar Model 51 Viso Cardiette — in use today throughout the world — is available as always. This larger, heavier (34 lb.) instrument is the "office standard" in thousands of practices. Price \$785 delivered.



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MEDICAL DIVISION

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BOOMERANG?

—NO!

When your patient calls again
—it will be to say “thanks”

because

symptoms do not recur—
complications do not supervene

AZO GANTRISIN

ANALGESIC ANTIBACTERIAL

Especially for urinary tract infections

ROCHE LABORATORIES

Division of Hoffmann-La Roche Inc
Nutley 10, N.J.



GANTRISIN® BRAND OF SULFISOXAZOLE

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Pyribenza

Pyribenzamine[®] EXPECTORANT breaks up cough

even persistent cough



Patient, factory worker, age 43, had suffered for months with persistent, dry cough, which he termed "smoker's hack."

Cough frequently interrupted his sleep, causing him to be nervous, irritable; his job efficiency was impaired.



Chest X-ray was negative and the plant physician prescribed PYRIBENZAMINE EXPECTORANT with Ephedrine. Patient noticed almost immediate relief—a week later felt "considerably better."



Pyribenzamine Expectorant with Ephedrine provides a unique combination of anti-tussive agents, which work three ways at once to break up the persistent cough: *Pyribenzamine* relieves histamine-induced congestion throughout the respiratory tract; *ephedrine* relaxes the bronchioles and makes breathing easier; *ammonium chloride* liquefies mucus, relieving dry cough and promoting productive expectoration.

Supplied: Pyribenzamine Expectorant with Ephedrine, containing 30 mg. Pyribenzamine citrate (equivalent to 20 mg. Pyribenzamine hydrochloride), 10 mg. ephedrine sulfate and 80 mg. ammonium chloride per 4-ml. teaspoon.

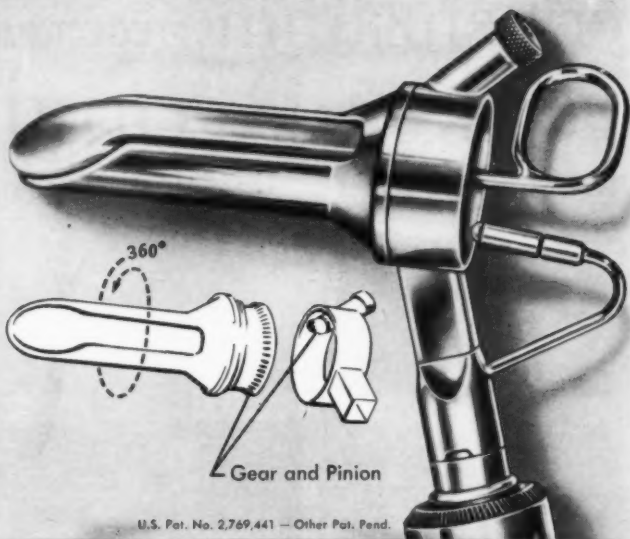
Also available: Pyribenzamine Expectorant with Codeine and Ephedrine, same formula as above with the addition of 8 mg. codeine phosphate per 4-ml. teaspoon (exempt narcotic).

Pyribenzamine[®] citrate (tripelennamine citrate CIBA)

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SUMMIT, N. J.



NEW ROTATING ANOSCOPE

Facilitates examination and instrumentation

- Speculum can be rotated without moving handle. Simple mechanism turns speculum through full 360°.
- Orbiculated edges minimize discomfort as speculum is rotated, even in the presence of rectal pathology.
- Entire instrument can be autoclaved or boiled, including the light carrier and lamp.
- Brilliant self-illumination with durable Welch Allyn No. 2 lamp.

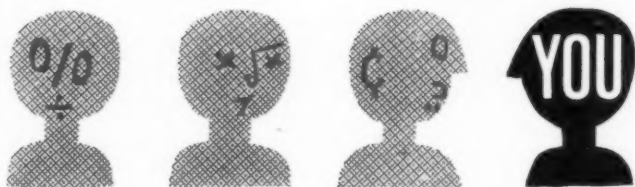
At your surgical supply dealer soon.

WELCH ALLYN
LIGHTS THE WAY

Medical Economics

INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, OCT. 27, 1958

What the New Depreciation Rules Mean to



Now you can write off the cost of your medical equipment faster than ever before. This article tells how and when to do it

By Joseph F. McElligott

Just after Congress passed the Small Business Tax Revision Act of 1958, one of my doctor-clients phoned me. He'd read about the measure in the newspapers and had discovered that the new and more liberal depreciation rules

could save taxpayers \$175,000,-000 in a single year. "How much money can I save?" he wanted to know.

In the weeks since then, other doctors have asked me the very same question. My quick answer:

THE AUTHOR, a tax and medical management consultant in New York City, was formerly employed by the Government as an Internal Revenue agent.

NEW DEPRECIATION RULES

"You may be able to get an extra tax deduction of up to \$4,000 for 1958; or you may save little or nothing. But the total of your deductions won't be any greater in the long run. You'll simply be able to claim larger amounts earlier."

As I've said, that's just a quick answer. Now let me explain it in detail:

What Congress has done is to allow small businessmen (including doctors) a big extra depreciation deduction in the first year they buy an item of equipment. The idea is to make it easier for such individuals to invest in income-producing property.

The new rule changes only the rate at which you can charge off your professional investments, *not* the total amount that you can depreciate. The total's the same as it always has been: the original cost of the equipment less its estimated salvage value. But you now have a better chance than ever before to write off your equipment in the way that'll do you the most good.

You don't have to take advantage of the new method. In fact, you'll do better not to in some cases. It'll take a little arithmetic to decide which is the best way

for you. But the results will be worth the effort.

Here, then, are the most pertinent questions doctors have been asking me about the new rules, along with my answers:

Is there a limit to the amount you can write off the new way?

Yes. You're allowed the special depreciation treatment for only the first \$10,000 you invest in income-producing equipment. But if you file a joint return with your wife, the new rules apply to as much as \$20,000 of such investment in any given year.

How do you handle the depreciation on that \$10,000 or \$20,000 investment?

The law allows you a one-shot 20 per cent deduction of the cost of either new or secondhand equipment in the first year you buy it. If you buy the equipment new, you can depreciate the remaining cost just as you would have done in the past, by either the straight-line method or a stepped-up method. If the equipment is used, the remaining cost can only be written off on the straight-line method. Either way, you actually get a *double* deduction in the first year: the flat 20

per cent allowance *plus* the allowable depreciation on the remainder.

For example, let's say you've just bought a \$10,000 used X-ray machine with a useful life of ten years and an estimated salvage value of \$1,000 at the end of ten years. The law requires you to write it off on the

straight-line method. But before Congress passed the new act, that's all you could deduct—\$900 each year for the ten-year period.

Under the new law, you begin by deducting a flat 20 per cent of the machine's \$10,000 cost: \$2,000. When you subtract this and the \$1,000 salvage value



"... and, getting closer to the present, here we have my grandfather on my mother's side. Then ..."

NEW DEPRECIATION RULES

from the cost, you get \$7,000 to spread over the ten years.

Thus, your annual depreciation deduction will be \$700. And for 1958 you can deduct \$2,700, instead of the \$900 you'd have been allowed under the straight-line method alone.

If you had purchased the machine new and prefer the declining-balance type of depreciation, your first year's deduction would be even bigger. You could still claim the \$2,000 allowance. But the normal first-year depreciation for the rest of the machine's cost would be \$1,600 if you figured it on the declining-balance method. So your total depreciation deduction for 1958 would be \$3,600.

Remember, though, that if the equipment you've bought costs more than \$10,000 in any one year—or \$20,000, if you and your wife file a joint return—you can claim only the normal depreciation on the excess. That's why your maximum annual saving is \$4,000 (20 per cent of \$20,000).

Can all your professional property qualify for the special first-year write-off?

No. The law applies only to

tangible personal business equipment—e.g., machinery and furnishings—with a useful life of at least six years. You can buy such equipment either new or used. But any item with a useful life of under six years doesn't qualify. And neither do buildings.

When does the new rule go into effect?

It's already effective for calendar-year taxpayers. All equipment you've bought since Jan. 1, 1958, qualifies for the special first-year deduction. You can claim it on your 1958 tax return.

(One tip, by the way: If you want to take full advantage of the favored treatment, you'd better check over your purchases so far this year before you do any more buying. If you've already invested close to the maximum, you may want to defer further professional purchases until 1959. That way, all your equipment can qualify for the tax break.)

Suppose you trade in some equipment you now own on new equipment. How does this affect the write-off?

Only the extra cash you have to lay out qualifies for the 20 per cent deduction. [More on 194]



HOW SOLO DOCTORS

DIVIDE UP



OFFICE WORK

How much work do you delegate to your aide or aides?

*Here's what your colleagues do—and why you
should know what they do for your own protection*

By Hugh C. Sherwood

Do you delegate too many, too few, or just about the right number of tasks to your office help? Nobody can give you a sure answer to that question without considering your particular circumstances. But you can get a rough idea of your efficiency as a delegator by comparing your ways with those of your colleagues.

To help you make such a comparison, MEDICAL ECONOMICS has asked several hundred doctors how thirty common duties are handled in their offices. The question: Which of the following jobs do you assign to your aide or

WHO DOES WHAT IN ONE-AIDE OFFICES

	Doctor	Aide
<i>Greets office visitors</i>		●
<i>Screens incoming calls</i>		●
<i>Makes appointments</i>		●
<i>Opens and sorts mail</i>	*	●
<i>Prepares correspondence</i>	*	●
<i>Transcribes dictation</i>		●
<i>Files letters and case histories</i>		●
<i>Orders secretarial supplies</i>		●
<i>Prepares insurance forms</i>	*	●
<i>Files financial cards</i>	●	*
<i>Keeps financial records</i>	*	●
<i>Discusses pay arrangements</i>	●	
<i>Prepares monthly statements</i>		●
<i>Deposits checks and cash</i>	●	*
<i>Follows up delinquent accounts</i>	●	*
<i>Writes checks to pay bills</i>	●	
<i>Reconciles bank statements</i>	●	
<i>Orders clinical supplies</i>		●
<i>Sterilizes instruments</i>		●
<i>Prepares patients for examination</i>		●
<i>Assists during treatment</i>		●
<i>Performs urinalyses</i>	*	●
<i>Changes dressings</i>	●	*
<i>Gives injections</i>	*	●
<i>Takes electrocardiograms</i>	●	
<i>Takes case-history data</i>	●	
<i>Prepares case histories</i>	●	
<i>Administers diathermy</i>	●	
<i>Takes and develops X-rays</i>	●	
<i>Performs metabolic tests</i>	●	

*This duty is handled by the person starred in a significant number of the surveyed offices, though not in the majority of them.

WHO DOES WHAT IN TWO-AIDE OFFICES

2

	Doctor	1st Aide	2nd Aide
<i>Greets office visitors</i>			●
<i>Screens incoming calls</i>			●
<i>Makes appointments</i>			●
<i>Opens and sorts mail</i>			●
<i>Prepares correspondence</i>			●
<i>Transcribes dictation</i>			●
<i>Files letters and case histories</i>			●
<i>Orders secretarial supplies</i>			●
<i>Prepares insurance forms</i>			●
<i>Files financial cards</i>	*		●
<i>Keeps financial records</i>			●
<i>Discusses pay arrangements</i>	*		●
<i>Prepares monthly statements</i>			●
<i>Deposits checks and cash</i>	*		●
<i>Follows up delinquent accounts</i>	*		●
<i>Writes checks to pay bills</i>	●		*
<i>Reconciles bank statements</i>	●		*
<i>Orders clinical supplies</i>		●	
<i>Sterilizes instruments</i>		●	
<i>Prepares patients for examination</i>		●	
<i>Assists during treatment</i>		●	
<i>Performs urinalyses</i>		●	
<i>Changes dressings</i>		●	
<i>Gives injections</i>		●	
<i>Takes electrocardiograms</i>	●		
<i>Takes case-history data</i>	●	*	
<i>Prepares case histories</i>	●		
<i>Administers diathermy</i>	●	*	
<i>Takes and develops X-rays</i>	●	*	
<i>Performs metabolic tests</i>	●	*	

*This duty is handled by the person starred in a significant number of the surveyed offices, though not in the majority of them.

HOW SOLO M.D.s DIVIDE UP OFFICE WORK

aides, and which do you handle yourself? The doctors' answers are tabulated on pages 74 and 75.

The first table sets forth the replies of solo practitioners who have only one aide. The second does the same thing for solo men with two aides.

In the surveyed one-aide offices, more than half the girls are either nurses or technicians. The doctors classify most of the rest as medical secretaries or receptionists. But in almost all cases, the aides live up to the nickname "Girl Friday" by doing several tasks outside their particular job classifications.

In the two-girl offices, all aides labeled "1st Aide" in the table are nurses or, occasionally, technicians. Those labeled "2nd Aide" are medical secretaries, receptionists, or bookkeepers, *not* other nurses nor technicians.

If you study the tables, you'll find—not surprisingly—that the two-aide doctor is able to delegate a lot of work that the one-aide man has to do for himself. The practitioner with two aides appears especially likely to let the secretary handle three jobs that most one-aide doctors say they usually handle: discussing

pay arrangements, following up delinquent patients, and depositing checks and cash. In a number of cases, he is also prone to delegate more clinical duties as well.

But whether he has only one aide or two, the typical doctor doesn't take as much advantage as he might of his help, say men who've studied the situation. For instance, here's what Millard K. Mills of Professional Management Midwest, Waterloo, Iowa, has to say about MEDICAL ECONOMICS' findings:

'They Waste Time'

"The first table indicates that the doctor with a single aide usually files financial cards, discusses pay arrangements, follows up delinquent accounts, and reconciles bank statements. I believe he's guilty of mismanagement if he does any one of those things himself. It's fantastic that a man whose time is worth \$25 to \$35 an hour should spend it on tasks that any competent aide can be trained to do.

"The second table raises a similar question for the doctor with two aides. Why should he write checks to pay bills, reconcile bank statements, take elec-

trocardiograms, administer diathermy, take and develop X-rays, or perform metabolic tests? Such tasks can and should be delegated."

Where business duties are concerned, most authorities would probably agree with Mr. Mills. But the problem of delegating clinical duties is a delicate one. Consider what Howard Hassard, legal counsel to the California Medical Association, recently told the doctors of his state:

"While a literal application of the Medical Practice Act would prohibit the delegation of any medical function to a nonphysician-assistant, it is quite obvious that reason forbids any such literal interpretation . . . However, application of a rule of reason does not mean that wholesale, unnecessary, or publicly undesirable delegations of duties by

a licensed physician will be condoned.

"When faced with the necessity of deciding whether an act is or is not unlawful, the courts are very likely to be guided by established custom . . . *A physician who delegates functions that his colleagues do not delegate or do not consider safe to delegate is running the risk of legal charges of several types.*"

In view of the above warning, it may be a good idea for you to think twice before delegating clinical tasks that many of your colleagues don't delegate.

Now take a look at the tables. A small black dot signifies that the person indicated *usually* performs a given task. A star indicates that though the person starred doesn't *usually* handle the job, he or she does so in a significant number of the surveyed offices. END

• • • Fatty Tumor • • •

I'm sorry, ma'am, it isn't glands
Nor is it in your mind;
It's what you stuff into your mouth
That makes you bulge behind.

—COLBY CLEVELAND

The
Secret Hospital Report

DOCTOR HATED KAISER
SO HE LET A MAN DIE

The San Francisco
Secret Malpractice
Blasts Hospital

SECRET HOSPITAL REPORT

As a service to medicine, these doctors asked a psychologist to study some reasons for malpractice suits. But here's how a service can become a disservice: A newspaper man saw the report and took . . .

A ONE-EYED LOOK AT MALPRACTICE



GEORGE DUSHECK, the San Francisco News reporter who broke the story.

San Francisco News
Medical Report
Hospitals in Cal.

Bare Shocking Medic Report Doctors Battle

By Lois R. Chevalier

On an afternoon in late August, 1958, San Francisco doctors on their way to office hours were stopped dead in their tracks by the hoarse shouts of newspaper hawkers: "Secret medical report! Read all about it! Doctors blasted! Hospitals unsafe!"

All that week, Bay area papers thought to keep up with the San Francisco News' scoop. Front pages carried sensational headlines like those shown above, with these variations:

"DOCTOR HATED KAI-SER PLAN, SO HE LET PA-TIENT DIE"

"'GOOD' CARE CAN KILL PATIENTS"

"MEDIC REPORT SHOCK-ER: DOCTORS BATTLE"

Where did the sensational stories come from? The San Francisco doctors were shocked to discover that they stemmed from a study done for the California Medical Association by

Richard Blum, a psychologist. Somehow, News Writer George Dusheck had got hold of a copy of the Blum report; and it provided him with the material for a number of startling "revelations." For instance, here are the opening paragraphs of his first article on the subject:

"This is a story about a bad hospital. It operates right here in the Bay area. It is described in a secret report on hospital mal-practice problems, a report sponsored by the California Medical Association.

"From the outside it looks like any other modern hospital—clean and trim, standing on a quiet street on the outskirts of town. But here are some of the things a C.M.A. research team found:

"One staff member was on emergency duty at night when an ambulance brought in an accident patient. The nurse went

A ONE-EYED LOOK AT MALPRACTICE

through the patient's pockets while the doctor started to work on him. Then the nurse found a [Kaiser Foundation Health Plan] ID card on him. The doctor hated that [group], so he told the attendants to put the patient back into the ambulance.

"They did, but when the ambulance arrived at the [Kaiser Hospital] some miles away the patient was dead . . ."

Reporter Dusheck had plenty of similar stories to tell in his three-part series of San Francisco News articles. He and other writers—who soon got into the



JOHN BLUM, M.D., a Berkeley (Calif.) internist and president of the Alameda-Contra Costa Medical Association, was opposed to the hospital study from the start, although his Council voted to let the investigators go into their communities' hospitals.

Dr. Blum's 1,600-man society has done pioneer work in a number of fields. It set up one of the country's first grievance committees. It was the first U. S. medical society to guarantee medical care for all, regardless of ability to pay. It sponsored local studies on doctor-patient relations by Psychologist Ernest Dichter; and the results of those studies have influenced medical public relations techniques all over the country.

But with newsmen and frightened patients quizzing him about recent "revelations" in San Francisco's newspapers, Dr. Blum became increasingly bitter about motivation research. At the time, he didn't even have a copy of the report from which the revelations stemmed. Nor could he refer the queries to another man named Blum: The psychologist-author of the report had left for a European vacation just before the newspaper stories broke.

act—also found accounts in the Blum report of fights among doctors during surgery, and of physicians who carried guns to defend themselves from their colleagues. In addition to such anecdotes, the newspapers featured reports of incompetent anesthesia, unnecessary surgery, fragments of

broken instruments sewed up in patients.

Had this study actually been sponsored by the California doctors' state medical association? If so, had Reporter Dusheck quoted the study correctly? Where had Psychologist Blum got his information? MORE▶

RICHARD H. BLUM, Ph.D., is a young psychologist whose previous studies for the California Medical Association on the psychology of suit-prone doctors and patients have been widely praised for the soundness of their technique and findings. Doctors, at least, haven't yet begun to praise his new—and controversial—study of high- and low-suit hospitals.

To gather material for the now notorious Blum report, he talked at length with staff doctors, administrators, and chiefs of staff. He gave them standard psychological tests to measure personality characteristics. He administered questionnaires to internes, residents, nurses, medical records librarians, admitting clerks, telephone operators, and patients. He put observers on the wards, outside operating rooms, in hospital dining rooms, and at medical staff meetings. He studied statistics on admissions, abortions, deaths, infections, personnel turnover, board certification of staff members. He even talked to newspaper society editors about the social standing of the hospitals' trustees.

Were the results worth the effort? At the moment, many California doctors would bitterly deny they were.



A ONE-EYED LOOK AT MALPRACTICE

Physicians throughout the state were bewildered and angry. "Who's responsible for this mess?" was the furious question asked in many a staff room.

The doctor most embarrassed by the situation—if one doctor can be singled out—was John Blum, president of the Bay area's Alameda-Contra Costa Medical Association. The papers said that research for the report had been done in the hospitals of his two counties. What's worse, lots of people confused John Blum, M.D., with Richard Blum, Ph.D., who'd made the damning statements about medicine.

Soon, however, a clearer picture of what had happened emerged:

Psychologist Blum had been retained by the California Medical Association to look into the underlying reasons why doctors on some hospital staffs are sued for malpractice more often than doctors on other hospital staffs. That differentiation had been established by Dr. Joseph Sadusk, former chairman of the state society's malpractice committee. He'd observed that the doctors on the staff of one Bay area hospital had 33 suits per 100,000 admissions compared with a



GEORGE CRAWFORD promises that his committee of California assemblymen will "determine whether the charges against hospital-staff doctors are true. If they are, we must determine what legislation is necessary to correct the condition."

median rate of 12 suits per 100,000 admissions in Alameda and Contra Costa counties generally. And the "best" hospital in the area had a record of only 2.2 suits per 100,000 admissions.

So, as part of a mammoth two-and-a-half-year study of malpractice, Richard Blum had been authorized to compare some of the "best" hospitals ("best" from the malpractice-suit standpoint) with some of the worst. He'd in-

investigated two "good" and three "bad" institutions in painful detail.

Naturally, such an inquiry had to have a lot of official backing. And it got it.

"They asked if they could do the study in Alameda and Contra

Costa counties," explains a spokesman for the two-county society. "What could we say? We had to cooperate. The chairman of the C.M.A. malpractice committee was one of our members, Joe Sadusk. Our council couldn't turn him down, though many of

MAJOR FINDINGS OF THE BLUM REPORT

San Francisco papers headlined only the spectacular—and not always trustworthy—elements in Richard Blum's monumental hospital study. Psychologist Blum's *main* conclusions aren't sensational, and they may well be of interest to thoughtful doctors everywhere. Among his findings:

1. High-suit* hospitals have disharmony in the medical staffs, are less selective than low-suit institutions in granting privileges, and do a poorer job of committee work.
2. High-suit hospitals have fewer board men and more psychologically maladjusted doctors on their staffs.
3. High-suit hospitals provide fewer personnel per bed, pay lower salaries, have lower employee morale.
4. High-suit hospitals are less competently administered than low-suit hospitals.
5. High-suit hospitals have fewer strong, stable, and community-minded trustees.
6. High-suit hospitals have a poorer reputation in the community.
7. But high-suit hospitals don't differ from low-suit ones in assets, facilities, or accreditation status.

*The terms "high-suit" and "low-suit" are descriptive of the number of suits against staff doctors, not necessarily of the number of suits against the hospitals themselves.

A ONE-EYED LOOK AT MALPRACTICE

us had misgivings. And what did we get for it? A lot of corridor gossip and smut spread all over every paper in the Bay area."

When Psychologist Blum had finished accumulating his data, he had a 341-page document. Much of it was full of terms like "discrepancy index," "communality," "personality variables," and "mean CPI scores" ("unintelligible to anyone except another psychologist," according to John Hunton, C.M.A. executive secretary). Much of the rest of it was a measured, unsensational review of the problem, including a good many sober findings that could be of service to doctors everywhere.

But there were two single-spaced pages of miscellaneous comment from staff members and other people in and around one high-suit hospital. And those two pages were the stuff that headlines are made of.

Researcher Blum himself put in a disclaimer about this section of his report. "During the course of the research," he wrote, "a good number of informal comments, spontaneous interviews, and unsolicited information came to the attention of the investigators. Ordinarily such

materials are considered to have questionable value . . . However, since they are so consistent with other data and since they provide rather rich materials which supplement the earlier chapters, they are presented here in some detail."

When the work was finished, the psychologist turned his manuscript in to the C.M.A. office. About fifty copies were mimeographed for key medical leaders in the state and for outside consultants in psychiatry, sociology, and motivation research. But before any such interested parties had had a chance to study it, the headlines were exploding like fireworks.

How Did It Get Out?

How did George Dusheck get hold of a copy and open it up to the "rich materials" on pages 149 and 150? "I wish to God I knew," says C.M.A. Executive Secretary John Hunton. So far, no one apparently knows—or will tell.

But no matter how it happened, the news did get out. And it has had state-wide repercussions. Only a few days after the story broke, a subcommittee of the State Assembly Committee

on Public Health had already convened for a special session on the matter.

The legislators met in an atmosphere of public alarm—an alarm that was heightened by a statement reporters elicited from Dr. Malcolm H. Merrill, chief of the state health department. Admitted Dr. Merrill: Licensing of hospitals “does not concern itself with professional services—just physical plant, facilities, fire protection.” So Californians in general were suddenly made to realize that “nobody polices standards of medical service and ethical conduct in hospitals, except the doctors themselves—who are reluctant to act against each other,” as the San Francisco News editorialized.

When the legislative subcommittee met, Howard Hassard, attorney for the C.M.A., was ready with a statement. He told the assemblymen that California's doctors were earnestly seeking ways to improve the malpractice situation by studying the whole question of physician-patient relations. “The C.M.A. has spent \$178,157 on this endeavor during the past three years,” he explained. And he went on:

“The current report, together

with a number of other reports, must be calmly appraised and evaluated . . . It is unfortunate that the press stories which have caused your committee to gather today have been pretty much restricted to a few verbal, unverified items.”

‘Shocker’ Explained

Mr. Hassard discussed the facts behind one of the horror stories in detail—the lead-off story of the emergency patient who'd been refused treatment by a private hospital and sent to the Kaiser Hospital, where he was D.O.A. Actually, he pointed out, the case had gone to trial and the doctor had been exonerated by an 11-to-1 jury verdict. The patient had had a severe head injury; and the private doctor, a G.P., had rightly sent him to the large Kaiser Hospital, where there were equipment and specialists for neurosurgical cases.

John Blum, M.D., told the legislators that his county society had investigated all the rumors and allegations, some of which dated back as much as seven years. But the legislators felt the charges couldn't be dismissed on the testimony of medical society

A ONE-EYED LOOK AT MALPRACTICE

spokesmen. They requested George Crawford, chairman of the subcommittee on hospitals of the Assembly Committee on Public Health, to conduct a further investigation.

"He's a capable fellow, eminently fair. I think he'll do a good job," says C.M.A. President Francis West. "It may become apparent that in our efforts to find the right answers we've been somewhat persecuted."

Many California doctors fear that such optimism may be just whistling in the dark. During the two and a half years that Richard Blum has been investigating the malpractice situation, his work has had something less than unanimous support. In fact, in a footnote in the report, he says: "Some doctors doubted that a research branch of organized medicine could be trusted to keep their individual replies in confidence." The doctors' opposition to the idea of psychological research has hardly been softened by the current fracas.

Meanwhile, California medical men are waiting for a sober analysis of the Blum report from their own colleagues. They're also trying to discover the chief source of their disenchantment.

Is their major complaint against the press? Or is it against this sort of research by non-M.D.s?

"There's no doubt that this affair has set back progress in improving the standards of medical care by ten or fifteen years," says Joseph Sadusk, who resigned from the C.M.A. malpractice committee some time before the study he'd initiated was completed. "An honest attempt to better things for the public has served only to stir up public antagonism."

Nevertheless, the C.M.A. Council voted to set up a permanent research department just three weeks after the headline scare. What kind of research it will do hasn't been announced.

Some Good in It

But what if Richard Blum's report hadn't got prematurely into the wrong hands? Some observers believe the study is by no means the disservice to medicine that it may now seem to be. They consider many of the psychologist's findings in his previous research for the C.M.A. both significant and helpful. The *positive* aspects of Blum's work will be discussed in later issues of MEDICAL ECONOMICS. END

Start Planning



Next Year's Income!



How much more will you need to cover higher office expenses? Where will it come from? Decide now

By Charles Miller, M.D.

About this time of year, three medical partners I know take stock of their financial position and work out a professional budget for the year ahead. It's a simple process and a useful one. In fact, I'm surprised that more doctors don't do it.

Consider my three friends. In November, 1957, they sat down to estimate how much their professional expenses would increase during 1958. They totted up some desired increases in office salaries, the cost of some proposed office

START PLANNING NEXT YEAR'S INCOME

improvements, plus other new outlays they felt necessary. They found that they'd have to increase their earnings by almost 10 per cent just to cover these new expenses.

Where would this new income come from? Their collection ratio (then 84 per cent) was obviously open to improvement. They decided that a better billing system, plus telephone follow-ups, should bring in 6 per cent more. Another 4 per cent increase in earnings was planned through revision of selected fees.

Today, twelve months later, they're doing even better than

they'd hoped. Their calculations worked out right on the basis on which they figured. That is, the fee increases and the collection improvements have already covered their extra expenses. But they didn't figure on the growth of the practice. Its volume is running about 10 per cent higher this year, thus boosting their earnings that much more.

Would their incomes have increased *without* any advance planning? Perhaps—but probably not so much. In medical practice, as in military marksmanship, having a target always helps. END

H *Heaven Has Enough to Do*

A pleasant, well-to-do dowager came to me for a complete physical examination. She emphasized that nothing was to be overlooked. Since this was my first month in practice, I was most happy to oblige.

After an exhaustive study, I told her that she was in very good shape, that the only thing wrong with her was a minor irritable-colon condition.

When she failed to return for a follow-up, I was disappointed and rather puzzled. But some weeks later, a phone call from her cleared things up. "I feel I owe you an explanation, Doctor," she said. "You see, I wanted to be *sure* I was in good health before I took up Christian Science."

—WILLIAM S. HAUBRICH, M.D.



Do YOU Need a Psychiatrist?

These doctors did—not for themselves but for their patients. They've learned how a psychiatrist can prosper and provide all sorts of help even in a small community

By Nicholas Phipps

Psychiatric practice in many a small town is doomed to failure. For one thing, there's the question of economics. The rural maladjusted often can't afford to pay \$20 or \$25 a visit. For another thing, there's the problem of ignorance and prejudice combined.

The latter problem is apparently the more serious of the two. As one psychiatrist who fled to New York from a catastrophic year in a far-away town has put it: "They can pay your fees all right if they feel they need treatment. But they can't *feel* the need unless their family doctors educate them up to it. What was lacking in my small town was an informed and cooperative attitude on the part of the G.P.s."

Can the psychiatrist do well when he and the local medical men see eye to eye? The answer, as indicated by one practitioner's experience: Indeed he can. Dr. George Constant practices psychiatry with signal success in Victoria, Tex., which had a population of only 16,000 when he opened his office there six years ago. He has made such an impact on the rapidly growing town that the Texas Junior Chamber of Commerce has



Psychiatrist George Constant started practice in Victoria, Tex., six years ago, when town's population was only 16,000. He's been surprisingly successful there.

named him one of the state's five outstanding young men.

Listen to what he himself says about his career in Victoria: "From the beginning, my G.P. colleagues have worked with me for the good of all our patients. Without such cooperation, I'd have got nowhere."

Cooperation is a two-way street, of course. Dr. Constant's colleagues point out that he works with *them*, too. For instance, unlike some psychiatrists, he's always willing to discuss a

patient with the referring doctor. Sometimes he'll even give an informal opinion over the phone.

Proof of his good relations with the county's G.P.s is the fact that he has persuaded a community hospital to set aside thirty-four of its 120 beds for psychiatry. Indeed, the family doctors confess that they sometimes unload their more troublesome cases on the one psychiatrist in the county. "Many of these are referred," says one Victoria G.P., Dr. Andrew Tomb, "for the same reason a quarterback calls for a punt: to avoid being thrown for a loss."

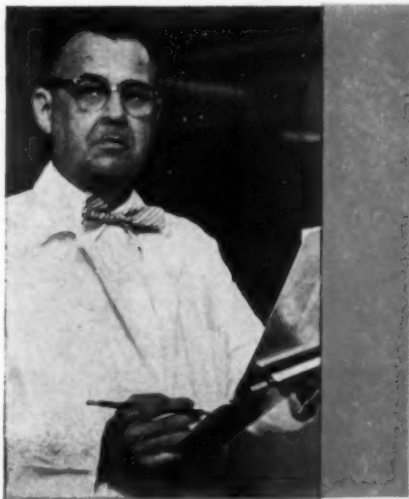
Dr. Tomb has played a special part in the Constant success story. In 1952, when 33-year-old George Constant arrived in Victoria, he and the town were strangers to each other. So he approached Dr. Tomb (who was, and is, active in the affairs of the Texas Academy of General Practice) to ask the G.P. what he thought of the prospects for psychiatric practice there.

Dr. Tomb's answer: "You may get along all right if you can remove the stigma from psychiatry. But you'll also have to prove you can fit yourself into the life of the community. I'll be

glad to help you with both tasks."

So the older man introduced the young psychiatrist to Victoria's doctors. And he helped him to understand the town itself. They've been working closely together ever since. To see just how closely, consider their usual routine:

They don't rely too heavily on formal reports. Often they just talk things over between them, as at a case conference. When Dr.



Dr. Andrew Tomb, a G.P., helped Dr. Constant get started. The two men have separate offices but work together closely.



Tomb wants a psychiatric interpretation of a patient, he has Dr. Constant interview him. If the patient can't afford a consultation, the two doctors talk the case over informally.

George Constant works in pretty much the same fashion with his other colleagues. But his relationship with Dr. Tomb is rather special. In fact, it's so close that, though they have separate offices, the G.P. covers for the psychiatrist when the latter is out of town.

"I go in only when specifically

called," Dr. Tomb explains. "And I'm careful to do more listening than talking. If I talked too much, I might start the patient on a train of thinking that would hamper Dr. Constant's psychotherapy. But it seems to help some patients just to have another doctor to talk to, when their own doctor is unable to make his usual rounds."

Dr. Constant has taken to heart Dr. Tomb's advice on becoming a member of the community. As you might expect, he has been especially active in



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Main St., Victoria. Town had no psychiatrist until 1952, when local doctors encouraged one to come there.

Victoria's educational circles. Among his pet projects to date:

He has helped start a school for handicapped children. He has organized a psychiatric consulting service for the schools. He conducts weekly seminars in psychiatry for interested doctors, nurses, occupational therapists, and clergymen. He has founded an automobile club for high-school kids. He has helped to organize both a civic adult theatre group and a children's theatre.

But what of economics? How does George Constant make his practice support him?

First, like all small-town doctors, he has developed a broad general approach. He's a neurologist as well as a psychiatrist. So he's consulted on head injuries, epilepsy, and paralysis.

Then, too, he willingly makes house calls. He sees juvenile delinquents, nagging wives, drunken husbands, homosexual brothers, quarrelsome sisters. He examines hermits, drug addicts, hysterical girls, spoiled brats of boys, would-be suicides. He's a

criminologist, marriage counselor, pedagogue, administrator, and universal uncle.

Incidentally, he charges \$25 a visit, like any psychiatrist in New York. But in half his cases he gets no fee at all.

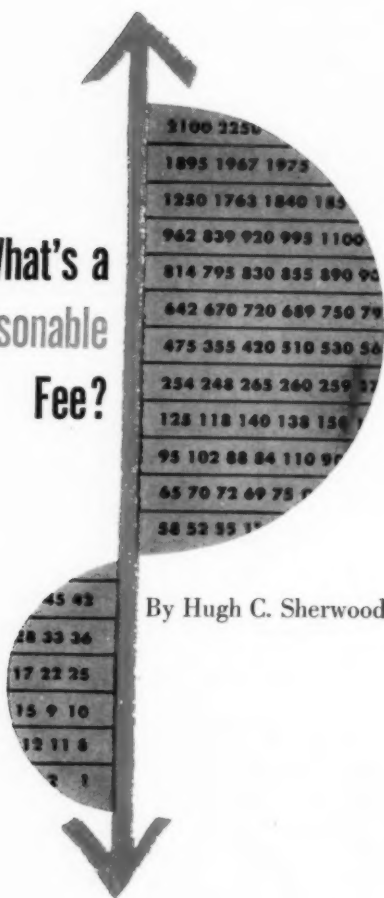
One measure of a doctor's success is his income; Dr. Constant's income is good. Another is his reputation within the profession; Dr. Constant's stands high in Victoria and in Texas. Still another is his influence on the community. Consider this fact:

Victoria has integrated its schools. Quietly. One grade at a time. No riots. No newspaper headlines. Merely disciplined conformity to the law of the land.

Dr. George Constant was chairman of the town's committee to facilitate desegregation. He'll tell you that the good sense and good humor of leaders of both races were responsible for this happy outcome. But those leaders are unanimous in saying that chief credit goes to the initiative and persuasiveness of Victoria's only psychiatrist. END

At one of his regular seminars, Dr. Constant discusses psychiatric problems with local civic and medical leaders.

What's a Reasonable Fee?



By Hugh C. Sherwood

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**You have your ideas, but courts of law
may have others. Here are the four criteria on which
they're likely to base their decisions**

Four years ago this fall, you may remember, all Brooklyn wore a hangdog look. The Dodgers hadn't yet been lost to Los Angeles. But they had lost the National League pennant to the Giants.

What was almost as disheartening, the Dodgers' star catcher, Roy Campanella, had had a mediocre season. And unless his sore left hand could be put in shape, there wasn't much hope that he'd do better in 1955.

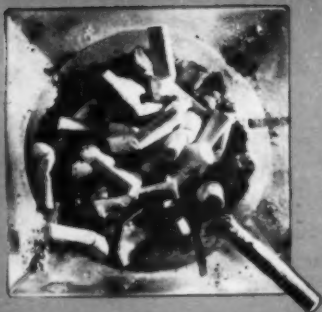
But Campanella's hand was put in shape. In 1955, the Dodgers won both the pennant and the World Series, and their great catcher was voted the National League's most valuable player.

The man mostly responsible for this happy state of affairs was a New York City neurosurgeon, Dr. Samuel Shenkman. The procedure he performed for Campanella was an internal neurolysis. His fee for the operation and a

few postoperative visits came to \$9,500.

Sound reasonable to you? Well, it didn't to the Dodgers. When Campanella passed Dr. Shenkman's bill on to his bosses, they refused to pay. Exploded Dodger President Walter O'Malley, in language that later became part of the subject of a slander suit brought by Dr. Shenkman: "It appears that [Dr. Shenkman] thought he was operating on Roy's bankroll . . . He offered to arbitrate before a committee of doctors. I told him I preferred a jury of people who pay doctors' bills, not send them."

With no choice left to him, the doctor sued to collect his fee, and the case was permitted to come to trial. The jury then had to decide two questions: Had there been a prior agreement on the fee? (The doctor maintained there had been such an agree-



for habit-induced

hyperacidity

prescribe

refreshingly flavored

Gelusil

antacid adsorbent

fast, lasting relief

nonconstipating

contains no laxative

WARNER-CHILCOTT

WHAT'S A

REASON

ment; the ballplayer denied it.) If not, what would a fair fee be in this case?

In its verdict, the jury indicated its belief that there had been no agreement. So it set its own fee.

Before doing so, however, it listened to a great deal of testimony from doctors about what a reasonable fee would be. Such testimony was of real importance. When a suit to recover a fee goes to trial, the most vital question the court is likely to ask is this: What are the usual charges of physicians of like status for like services?

Who Was Right?

Campanella produced several doctors who asserted that \$1,500 would be a reasonable fee for the operation that had been done on his hand. But other physicians testified as to the fairness of Dr. Shenkman's \$9,500 charge.

Faced with a conflict of opinion, the jury awarded Dr. Shenkman \$5,000. That's a much higher fee than many doctors in the New York City area would have levied for a similar service. But it's roughly only half what the doctor originally charged. Obviously, then, the jury was heavily influenced by the fact that a number of physi-

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REASONABLE FEE?

cians testified that Dr. Shenkman's fee seemed considerably out of line.

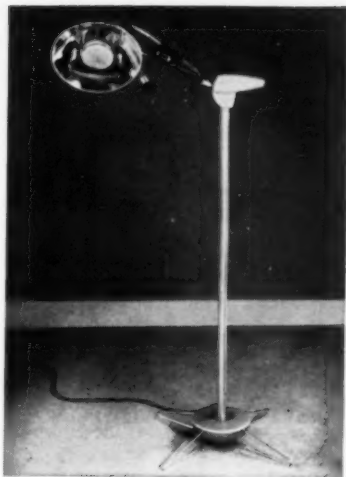
What's the significance of that decision for you? Well, it points up two facts worth thinking about if you ever consider suing a patient for a bill he believes exorbitant:

Courts of law do *not* judge the fairness of a fee in relation to the importance of the service to the patient. Nor—in most states, at least—do they judge it in relation to the patient's ability to pay.* Generally speaking, the criteria on which fee judgments are based are concerned exclusively with the fairness of charges from the *doctors'* point of view.

So before you go to law over a given fee, you'll do well to test the legal validity of your claim by asking yourself four basic questions:

1. *What are the usual charges of physicians of like status for like services?* This criterion dominated the Campanella case. It's apparently of primary importance. Indeed, all the other criteria stem from it. MORE►

*If the procedure has been of little or no value, however, and if the physician has demonstrably failed to exercise reasonable care and skill, the fee will almost certainly be judged unreasonable. On the other hand, if the doctor can prove there's been an advance fee agreement, this will very likely influence the decision in his favor.



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WHAT'S A REASONABLE FEE?

2. *What was the nature of the case? Was the treatment hard to render, for instance? How much time did the case require? How many follow-up visits?*

3. *How much training and experience have you had, and how skillful are you? Are you a specialist? What's your age? How long have you practiced in your field?*

4. *What's your professional*

standing? How big is your practice? How big is your annual income? What are your usual fees? What professional societies do you belong to?

It almost goes without saying that courts don't interpret the answers to such questions with uniform regularity. But legal authorities agree that the four criteria are much more than a rough guide. In [More on 197]



"Could you make it the arm? I'm a bus driver."



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the metabolic demands of convalescents
and patients on long-term therapy*

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Each capsule-shaped tablet of NOVO-BASIC supplies:

Ascorbic Acid.....	150 mg
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Dosage: One or more tablets of NOVO-BASIC daily as indicated.

Supply: Bottles of 60 and 180 capsule-shaped tablets.

NOVO-BASIC is designed to meet the *daily* metabolic demands of convalescents and those on long-term therapy for adequate supplies of B and C vitamins. These water-soluble vitamins are *continuously being excreted and must continuously be replaced*. NOVO-BASIC is also indicated in patients receiving prolonged diuretic therapy where vitamin loss can be excessive.

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Some evening soon, some week-end, or any time before Jan. 1, 1959: **Write up your ideas** on one carefully limited aspect of any broad subject in our field—fees, for example, or practice management, or professional relations with other doctors.

Document your ideas with examples, anecdotes, and cases in point drawn from your own experience. The more such documentation, the better your chance of winning.

Send your article to the Awards Editor, MEDICAL ECONOMICS, Oradell, N. J.—the sooner, the better. Send in more than one article if you wish.

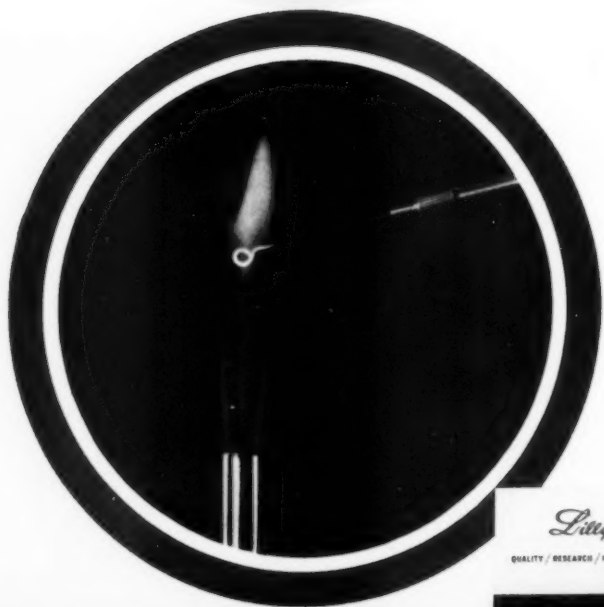
Please note: Manuscripts should be typed, double-spaced, on one side of the paper only, and accompanied by a self-addressed envelope and return postage. Awards are intended for articles between 1,000 and 3,000 words long. (Shorter or longer articles, if found acceptable, will be paid for at regular rates.) The editors of this magazine will be the judges; their decisions will be final.



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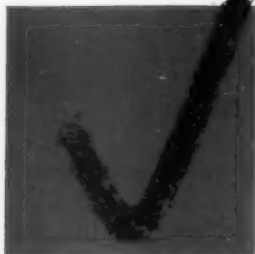
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'Ilotycin' is available as specially coated tablets, pediatric suspensions, drops, otic solution, ointment, ophthalmic ointment, and I.V. ampoules.

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How Well-Managed Is Your Practice?

*This self-test—the fifth
of a series—will help you evaluate
your collection methods and
cut your collection losses*

By Horace Cotton

Probably the best single indicator of a well-managed medical office is a respectable collection ratio. What's respectable? Well, it varies with the doctor's field of practice.

I'd say the obstetrician should have the best collection percentage of all. If he manages it right, he can insure that practically all of his money is in the till before he finishes his job. The pediatrician should collect well, too. He has a big volume of small charges, and his cash collections ought to be high. The radiologist shouldn't lose much either.

Good collections in other fields depend on bigger *ifs*. The urban G.P. should collect well *if* his office girl is really on

THE AUTHOR heads his own professional management firm, which has headquarters in Southern Pines, N.C., and offices in major cities throughout that state.

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Relieves the most common side-effect of reserpine

Approximately half of all patients taking any *Rauwolfia* preparation experience the annoying side-effect of nasal stuffiness. 'Sandril' c 'Pyronil' relieves nasal congestion in about 75 percent of your patients who experience this troublesome side-effect.

*'Sandril' (Reserpine, Lilly) †'Pyronil' (Pyrrobutamine, Lilly)

Each tablet combines:

'Sandril' 0.25 mg.
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Dose: Usually 1 tablet b.i.d.

Also 'Sandril': Tablets, 0.1, 0.25, and 1 mg. Elixir, 0.25 mg. per 5-cc. teaspoonful.

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HOW WELL-MANAGED IS YOUR PRACTICE?

her toes. The internist and the general surgeon can collect well if they discuss their charges with the patient in advance, instead of letting the month's-end bill break the bad news.

As for the country doctor, he's the guy with the biggest collection problem of all. I for one haven't been able to hammer out any rules that will put his collection percentage up there with the others.

So much for background. Now let's get down to specifics—and to you. Check off your answers to the following three

questions, and you'll soon see how *your* medical office rates:

1. What's your collection percentage?

Over 95 per cent. ☐

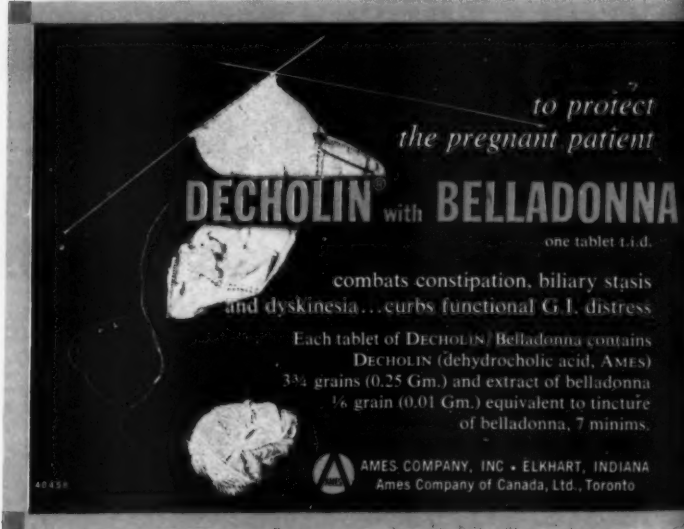
90 to 95 per cent. ☐

85 to 89 per cent. ☐

80 to 84 per cent. ☐

Under 80 per cent. ☐

If you don't know the figure, better work it out right now. It's one of the most vital figures in the business side of medicine. Get out your 1957 totals (or first half of 1958, if available). Divide "total business done" into



*to protect
the pregnant patient*


DECHOLIN with **BELLADONNA**

one tablet I.I.D.

combats constipation, biliary stasis
and dyskinesia...cures functional G.I. distress

Each tablet of DECHOLIN/Belladonna contains
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33½ grains (0.25 Gm.) and extract of belladonna
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'Trisogel' combines the prompt antacid action of aluminum hydroxide with the more sustained effect of magnesium trisilicate.

In the treatment of peptic ulcer, the usual adult dose is 1 or 2 tablespoonfuls every one to three hours.

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HOW WELL-MANAGED IS YOUR PRACTICE?

"total collections," and you've got it.

Is the percentage respectable? Here's how to tell:

If you're an OB man, pediatrician, or radiologist, I'd expect your collection ratio to be *above 95 per cent*. If you're a G.P., internist, or general surgeon, I'd expect it to be *at least 90 per cent*. (Just one exception: the rural G.P., for whom 80 per cent may be the norm.)

What if your collections aren't that good? Then something's wrong—and the next two questions may help you put your finger on it:

2. When do your bills get mailed out?

- Last day of month. . . . ☐
- First day of month. . . . ☐
- Mid-month. ☐
- Catch-as-catch-can. . . . ☐

The best answer is "Last day of month." This means your bills usually reach the patients on the first day of the month. You're right in there with all the other creditors—and it's important to be there at the right time.

Plenty of patients have to make a choice of the bills they'll pay right away. If yours isn't in the deck, it doesn't stand much

chance of being shuffled and cut.

One caution: When billing at the end of the month, don't bill for services rendered within the last few days. That looks a little "hungry."

It's best to have an earlier cut-off date—the twenty-fifth of the month, say. Then your girl has four or five days in which to get the bills ready for mailing. Even if a week-end falls between the twenty-fifth and the last day of the month, she can still make the deadline. Be sure the cut-off date is plainly printed on your statement.

3. What kind of statements do you use?

- Unitemized bills. ☐
- Itemized bills. ☐
- Business-reply statements. ☐
- Copies of patients' account cards. ☐

No one kind of statement is best for all practices. But unitemized bills ("For Professional Services . . . \$25") are definitely the "least best." Today's patients simply aren't satisfied by that type of billing, in my observation.

Itemized bills are much better. And they don't take too long

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'V-Cillin-Sulfa' combines the superior oral penicillin and three sulfonamides. Used concurrently, they produce faster and more effective antibacterial action in certain infections. In general, the combination is most beneficial in mixed infections, infections due to bacteria only moderately susceptible to either agent, and conditions in which bacterial resistance might develop. The much higher

penicillin blood levels produced by 'V-Cillin' (Penicillin V, Lilly) and the effectiveness and safety of the triple sulfas make 'V-Cillin-Sulfa' your most valuable preparation of its type.

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involves both muscles and joints

MEPROLONE®

THE FIRST MEPROBAMATE-PREDNISOLONE THERAPY

relieves both painful muscle spasm
and disabling joint inflammation

MEPROLONE is the first antirheumatic-antiarthritic designed to relieve simultaneously painful muscle spasm, joint inflammation and swelling, physical distress . . . to help prevent disability and accelerate return of normal function.

SUPPLIED: Multiple Compressed Tablets: MEPROLONE-1—1.0 mg. prednisolone, 200 mg. meprobamate and 200 mg. dried aluminum hydroxide gel (bottles of 100). MEPROLONE-2—provides 2.0 mg. prednisolone in the same formula as MEPROLONE-1 (bottles of 100).

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HOW WELL-MANAGED IS YOUR PRACTICE?

to make up if your secretary uses those perforated packs of about 500 billheads. She just puts the pack behind her typewriter, feeds in number one, and the rest of the pack follows as the typewriter platen revolves. This system is a great time saver.

The statement printed on a business-reply envelope is something I've recommended for years. The mass-circulation magazines were the first to prove that if you made it easy for people to mail in money, they tended to mail in more money than if you didn't make it easy. I believe that the prepaid business-reply state-

ment has pulled in many thousands of dollars for most doctors I've worked with—dollars that otherwise would have come in many months later, or maybe not at all.

As of now, however, I'm inclined to think that a copy of the patient's account card is the best kind of statement for most practices. Mind you, there are plenty of exceptions. But for speed and accuracy and full itemization, you can't beat billing by photocopy. Fifty medical offices I've worked with have proved it to my complete satisfaction. More about this subject later. **END**

Circular Surgery

My husband is also a doctor, and recently while trying to keep my 4½-year-old daughter occupied, I said: "Draw a picture of Daddy at work." Soon she presented me with her idea of a surgeon operating on a patient. At the top of this masterpiece, she'd drawn a row of circles. She'd never seen an O.R., so I asked her if the circles represented overhead lights.

She said disgustedly, "Those are *rounds*."

I looked puzzled, and she elaborated: "You know—Daddy makes them when he operates."

And then I remembered the hundreds of times her father had kissed her and said: "Good-by, Sweetie, Daddy has to go operate and make rounds."

—M.D., FLORIDA

both have a cold...
BUT ONLY ONE IS COMFORTABLE



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PROMPT DECONGESTANT ACTION
 Rapidly relieves nasal congestion, while giving the patient a welcome "lift"... with Phenylephrine.

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 Balanced ratio of chemically distinct antihistamines results in full potency with marked freedom from side-actions... with Chlorpheniramine and Pyrilamine.

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ANALGESIC ACTION FOR ADDED COMFORT

Potentiated effect of Salicylamide with acetophenetidin helps relieve depressing "aches and pains." Caffeine and ascorbic acid also provided.

Dose: One capsule three or four times daily.

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TAX TRAPS WHEN YOU HIRE A RELATIVE

run through a few real-life cases. I'll sketch each situation briefly. Then, before you read further, you tell *me* how you'd rule on the case.



1 Dr. Stone has been supporting his father, a retired machinist, by giving him \$5,200 a year. The doctor has been able to deduct only \$600 of it as a dependency exemption. So, in order to get tax relief on the remaining \$4,600, he puts the old man on his office payroll as an accountant—at a \$5,200 annual salary. Meanwhile, he continues to pay \$75 a month to the C.P.A. who has always taken care of his books.

Can he justifiably claim his father's salary as a business expense?

Answer: Of course not. First of all, the older man's services aren't necessary. Secondly, even if they were, the pay's out of line

—\$100 a week to the retired father against \$75 a month to a qualified expert.

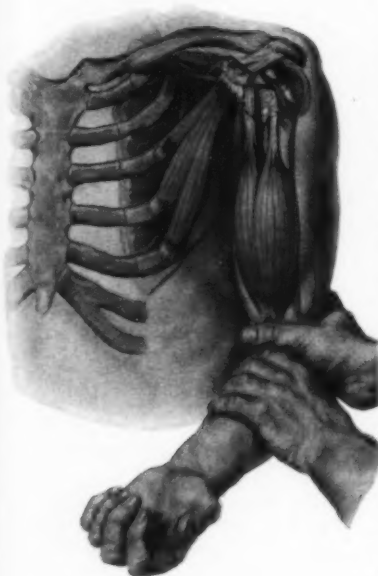
Not only that. A claim where services aren't actually performed could be considered tax evasion—and that means stiff penalties.



2 Dr. Dillingham used to refer some of his overdue accounts to a commercial collection agency, which charged 50 per cent of the sums collected. Now the doctor employs his retired uncle to follow up on old bills. The uncle gets his travel expenses, plus a flat \$25 a week, plus 25 per cent of everything he collects.

Can Dr. Dillingham deduct from his income tax not merely the uncle's salary but also his expenses and commissions?

Answer: Yes, he can. The job is a necessary one, since the uncle is performing a service the



NEW INDICATION:

Parenteral Priscoline®
relieves bursitis pain
in over 90% of cases¹

Frankel and Strider¹ report:

"Intravenous Priscoline gave excellent to good results in over 90% of our cases."

"Priscoline hydrochloride intravenously is an effective agent in the treatment of acute and recurrent acute subdeltoid bursitis."

The 150 patients in this study were given 1 ml. (25 mg.) Priscoline, by intravenous injection, daily from 1 to 3 days. Excellent results (relief gained immediately or within 24 hours; painless rotation of arm) were achieved in 71 patients. Good results (no sedation required; partial movement of arm without discomfort) were obtained in 68 patients. Eleven patients had no relief.

Patients' ages ranged from 22 to 85 years. Calcification was present in varying degrees in 82 cases. Sixty-nine patients reported previous attacks and had been treated unsuccessfully with X-ray, hydrocortisone and other agents.

The authors suggest it is the sympatholytic action of Priscoline which relieves pain by chemical sympathetic block. Further, "Priscoline may, through its vasodilating ability, promote the transport of calcium away from the bursa."

"We can especially recommend its use in cases where X-ray therapy or local injection of hydrocortisone has failed."

1. Frankel, C. J., and Strider, D. V.: Presented at Meeting of American Academy of Orthopaedic Surgeons, New York, N. Y., Feb. 3, 1958.

SUPPLIED: MULTIPLE-DOSE VIALS, 10 ml., 25 mg. per ml.

Also available: TABLETS, 25 mg.; ELIXIR, 25 mg. per 4-ml. teaspoon.

PRISCOLINE® hydrochloride (tolazoline hydrochloride CIBA)

Illustration by F. Netter, M.D., from CLINICAL SYMPOSIA 10: Cover (Jan.-Feb.) 1958.

C I B A
 SUMMIT, N. J.

TAX TRAPS WHEN YOU HIRE A RELATIVE

doctor used to buy from the collection agency. And the pay, which can't add up to much more than the collection agency was charging, is obviously reasonable.



3 Dr. Biddle was put through medical school by an aunt. In return, he's helping along her son, who's also studying medicine. For a couple of years, he gave the young student \$300 a month. The gift wasn't tax-deductible. Now the doctor has decided to hire his cousin as part-time business manager and medical assistant, at the same \$300 a month. This is the first time he has ever hired anyone in such a capacity; but he has long felt the need for some assistance.

Is the doctor entitled to a full deduction?

Answer: In this case, yes. His practice has grown to the point

where he has to have *someone* for the job. And the pay is by no means exorbitant considering the amount and quality of work that he's getting from his cousin in return.



4 Dr. Wright has always made a habit of talking over his cases with his physician-father. Now that the older man has retired, the younger physician would still like to get his medical opinions. And so he agrees to pay his father \$100 a week for his services as an "adviser."

If he does hire his father in such a capacity, can he claim a business deduction?

Answer: Probably not, if the "advisory services" are vague. On the other hand, let's suppose the son is an internist and the father a radiologist. All chest plates taken in the son's office are read by the father, who sub-

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your patients
nutritionally**

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of water-soluble vitamins **B and C**

ALLBEE[®] with C



Each capsule contains:

Thiamine	
Mononitrate (B ₁)	10 mg
Riboflavin (B ₂)	10 mg
Nicotinamide	50 mg
Calcium Pantothenate	10 mg
Pyridoxine	
Hydrochloride (B ₆)	5 mg
Ascorbic Acid	
(vitamin C)	250 mg

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Bottom line: Allbee with C is the only vitamin C supplement for your patients.

TAX TRAPS WHEN YOU HIRE A RELATIVE

mits an oral or written report. In any such case—where the services are clearly defined—the job could be considered a necessary one. If the salary paid for it is reasonable, the I.R.S. will allow the deduction.



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Illogical? Maybe. But if you're looking for logic, Doctor, don't look too closely at this country's tax structure.

END

Each 5 m
provides:
Triaminic
(phenyl-
phenyl-
pyrilan-
Dormeth-
HBr) .
Ammonia
In a plea
alcoholic



the cough quickly— end nasal congestion orally



- ▶ decongest the cough area
- ▶ control the cough reflex
- ▶ liquefy tenacious mucus

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Each 5 ml. teaspoonful of TRIAMINICOL provides:

Triaminic®	25 mg.:
(phenylpropanolamine HCl)	12.5 mg.;
pheniramine maleate	6.25 mg.;
pyrilamine maleate	6.25 mg.)
Dormethan (brand of dextromethorphan HBr)	15 mg.
Ammonium chloride	90 mg.

Is a pleasant-tasting, fruit-flavored, non-alcoholic syrup.

Triaminicol Syrup



running noses



and



cough



orally

TRAUMATIC A



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SUPPL
bamate
prednis

Meprolo



CARTHRITIS

involves both muscles and joints

MEPROLONE®

THE FIRST MEPROBAMATE-PREDNISOLONE THERAPY

relieves both painful muscle spasm
and disabling joint inflammation

MEPROLONE is the first antirheumatic-antiarthritic designed to relieve simultaneously painful muscle spasm, joint inflammation and swelling, physical distress . . . to help prevent disability and accelerate return of normal function.

SUPPLIED: Multiple Compressed Tablets: MEPROLONE-1—1.0 mg. prednisolone, 200 mg. meprobamate and 200 mg. dried aluminum hydroxide gel (bottles of 100). MEPROLONE-2—provides 2.0 mg. prednisolone in the same formula as MEPROLONE-1 (bottles of 100).

Meprozone is a trademark of Merck & Co., Inc.



MERCK SHARP & DOHME Division of MERCK & CO., Inc., Philadelphia 1, Pa.

HOW WELL-MANAGED IS YOUR PRACTICE?

to make up if your secretary uses those perforated packs of about 500 billheads. She just puts the pack behind her typewriter, feeds in number one, and the rest of the pack follows as the typewriter platen revolves. This system is a great time saver.

The statement printed on a business-reply envelope is something I've recommended for years. The mass-circulation magazines were the first to prove that if you made it easy for people to mail in money, they tended to mail in more money than if you didn't make it easy. I believe that the prepaid business-reply state-

ment has pulled in many thousands of dollars for most doctors I've worked with—dollars that otherwise would have come in many months later, or maybe not at all.

As of now, however, I'm inclined to think that a copy of the patient's account card is the best kind of statement for most practices. Mind you, there are plenty of exceptions. But for speed and accuracy and full itemization, you can't beat billing by photocopy. Fifty medical offices I've worked with have proved it to my complete satisfaction. More about this subject later. **END**

Circular Surgery

My husband is also a doctor, and recently while trying to keep my 4½-year-old daughter occupied, I said: "Draw a picture of Daddy at work." Soon she presented me with her idea of a surgeon operating on a patient. At the top of this masterpiece, she'd drawn a row of circles. She'd never seen an O.R., so I asked her if the circles represented overhead lights.

She said disgustedly, "Those are *rounds*."

I looked puzzled, and she elaborated: "You know—Daddy makes them when he operates."

And then I remembered the hundreds of times her father had kissed her and said: "Good-by, Sweetie, Daddy has to go operate and make rounds."

—M.D., FLORIDA

both have a cold...
BUT ONLY ONE IS COMFORTABLE



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brings comfort to her cold

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 nose*

PROMPT DECONGESTANT ACTION
 Rapidly relieves nasal congestion, while giving the patient a welcome "lift"... with Phenylephrine.

*Allergic
 manifesta-
 tions*

COMBATS HISTAMINE-INDUCED SYMPTOMS
 Balanced ratio of chemically distinct antihistamines results in full potency with marked freedom from side-actions... with Chlorpheniramine and Pyrilamine.

*Headache,
 Fever,
 Sore Throat*

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 Potentiated effect of Salicylamide with acetophenetidin helps relieve depressing "aches and pains." Caffeine and ascorbic acid also provided.

Dose: One capsule three or four times daily.

Supplied: Green and white capsules, bottles of 100

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Beware of These Tax Traps When You Hire a Relative



**Want to put your sisters and your cousins
and your aunts on the payroll? Go
ahead. But before you deduct their salaries, better
make sure you can justify the claim. Here's how**

BY M. J. GOLDBERG

Dr. Jansen's 16-year-old son works after school for his father. He does odd jobs around the office and runs errands to the town's medical laboratory.

"The kid has earned more than \$1,200 so far this year. He's saving it toward college," the doctor told me proudly the other day. "He's a big help around here. And what's more, I can claim his salary as a business deduction on my tax returns."

When I asked the doctor how many hours his son puts in, he answered: "Oh, I'd guess about an hour a day. Maybe 200 or 250 hours a year."

I did a little figuring on a scratch-pad. Young Jansen's earnings average at least \$5 an hour. At that rate, he's probably the highest-paid office boy in the state.

"If I were you, Doctor," I said, "I wouldn't try to deduct the full salary. You'll have a devil of a time selling such a deduction to the T-men."

Dr. Jansen's eyebrows lifted. "Oh?" he asked. "How come? I'm not trying to get away with anything. The boy really works hard."

So I explained what I was driving at. I told the doctor he had a perfect right to put his son or any other relative on the payroll. But he could consider the salary as a deductible business expense only if he could *justify* it as such.

How do you justify the deductibility of any salary you pay a member of your family? The Internal Revenue Service generally wants satisfactory answers to both of the following questions:

1. Is the job a necessary one, not merely a sinecure?
2. Is the rate you pay in line with prevailing local rates for the same kind of work?

On the first count, Dr. Jansen was in the clear. He undoubtedly needed an errand boy. But any I.R.S. man would have given him low marks on the second, since his youngster was being paid \$5 an hour for work his schoolmates would gladly have done for \$1.

So if you're paying a salary to someone in your family—or if you're thinking of doing so—you'll do well to test its deductibility by the above criteria. Just to get them clearly in mind, let's

TAX TRAPS WHEN YOU HIRE A RELATIVE

run through a few real-life cases. I'll sketch each situation briefly. Then, before you read further, you tell *me* how you'd rule on the case.



1 Dr. Stone has been supporting his father, a retired machinist, by giving him \$5,200 a year. The doctor has been able to deduct only \$600 of it as a dependency exemption. So, in order to get tax relief on the remaining \$4,600, he puts the old man on his office payroll as an accountant—at a \$5,200 annual salary. Meanwhile, he continues to pay \$75 a month to the C.P.A. who has always taken care of his books.

Can he justifiably claim his father's salary as a business expense?

Answer: Of course not. First of all, the older man's services aren't necessary. Secondly, even if they were, the pay's out of line

—\$100 a week to the retired father against \$75 a month to a qualified expert.

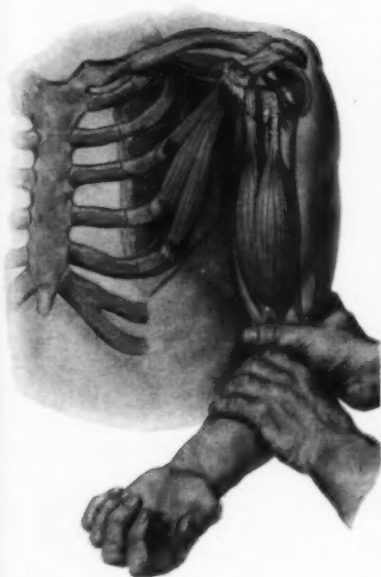
Not only that. A claim where services aren't actually performed could be considered tax evasion—and that means stiff penalties.



2 Dr. Dillingham used to refer some of his overdue accounts to a commercial collection agency, which charged 50 per cent of the sums collected. Now the doctor employs his retired uncle to follow up on old bills. The uncle gets his travel expenses, plus a flat \$25 a week, plus 25 per cent of everything he collects.

Can Dr. Dillingham deduct from his income tax not merely the uncle's salary but also his expenses and commissions?

Answer: Yes, he can. The job is a necessary one, since the uncle is performing a service the



NEW INDICATION:

Parenteral Priscoline®
relieves bursitis pain
in over 90% of cases¹

Frankel and Strider¹ report:
 "Intravenous Priscoline gave excellent to good results in over 90% of our cases."

"Priscoline hydrochloride intravenously is an effective agent in the treatment of acute and recurrent acute subdeltoid bursitis."

The 150 patients in this study were given 1 ml. (25 mg.) Priscoline, by intravenous injection, daily from 1 to 3 days. Excellent results (relief gained immediately or within 24 hours; painless rotation of arm) were achieved in 71 patients. Good results (no sedation required; partial movement of arm without discomfort) were obtained in 68 patients. Eleven patients had no relief.

Patients' ages ranged from 22 to 85 years. Calcification was present in varying degrees in 82 cases. Sixty-nine patients reported previous attacks and had been treated unsuccessfully with X-ray, hydrocortisone and other agents.

The authors suggest it is the sympatholytic action of Priscoline which relieves pain by chemical sympathetic block. Further, "Priscoline may, through its vasodilating ability, promote the transport of calcium away from the bursa."

"We can especially recommend its use in cases where X-ray therapy or local injection of hydrocortisone has failed."

1. Frankel, C. J., and Strider, D. V.:
 Presented at Meeting of American Academy of Orthopaedic Surgeons, New York, N. Y., Feb. 3, 1958.

SUPPLIED: MULTIPLE-DOSE VIALS, 10 ml., 25 mg. per ml.

Also available: TABLETS, 25 mg.; ELIXIR, 25 mg. per 4-ml. teaspoon.

PRISCOLINE® hydrochloride
 (tolazoline hydrochloride CIBA)

Illustration by F. Netter, M.D., from
 CLINICAL SYMPOSIA 10: Cover
 (Jan.-Feb.) 1958.

C I B A
 SUMMIT, N. J.

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TAX TRAPS WHEN YOU HIRE A RELATIVE

doctor used to buy from the collection agency. And the pay, which can't add up to much more than the collection agency was charging, is obviously reasonable.



3 Dr. Biddle was put through medical school by an aunt. In return, he's helping along her son, who's also studying medicine. For a couple of years, he gave the young student \$300 a month. The gift wasn't tax-deductible. Now the doctor has decided to hire his cousin as part-time business manager and medical assistant, at the same \$300 a month. This is the first time he has ever hired anyone in such a capacity; but he has long felt the need for some assistance.

Is the doctor entitled to a full deduction?

Answer: In this case, yes. His practice has grown to the point

where he has to have *someone* for the job. And the pay is by no means exorbitant considering the amount and quality of work that he's getting from his cousin in return.



4 Dr. Wright has always made a habit of talking over his cases with his physician-father. Now that the older man has retired, the younger physician would still like to get his medical opinions. And so he agrees to pay his father \$100 a week for his services as an "adviser."

If he does hire his father in such a capacity, can he claim a business deduction?

Answer: Probably not, if the "advisory services" are vague. On the other hand, let's suppose the son is an internist and the father a radiologist. All chest plates taken in the son's office are read by the father, who sub-

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Nicotinamide	50 mg.
Calcium Pantothenate	12 mg.
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Hydrochloride (B ₆)	5 mg.
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(Vitamin C)	250 mg.

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end nasal congestion orally



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- ▶ control the cough reflex
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Ammonium chloride	90 mg.

In a pleasant-tasting, fruit-flavored, non-alcoholic syrup.

Dosage: Adults—2 tsp. 3 or 4 times a day; children 6 to 12—1 tsp. 3 or 4 times a day; children under 6—dosage in proportion.

Triaminicol Syrup



running noses



and



cough



orally

If
Monilial
overgrowth
is a factor

Achrostatin^{*} V

TETRACYCLINE (PHOSPHATE-BUFFERED) AND NYSTATIN

SUPPLIED:

CAPSULES contain 250 mg. tetracycline HCl equivalent (phosphate-buffered) and 250,000 units Nystatin.
ORAL SUSPENSION (cherry-mint flavored) Each 5 cc. teaspoonful contains 125 mg. tetracycline HCl equivalent (phosphate-buffered) and 125,000 units Nystatin.

DOSAGE:

Basic oral dosage (6-7 mg. per lb. body weight per day) in the average adult is 4 capsules or 8 tsp. of ACHROSTATIN V per day, equivalent to 1 Gm. of ACHROMYCIN V.

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Combines ACHROMYCIN V with NYSTATIN

ACHROSTATIN V combines ACHROMYCIN V . . . the new rapid-acting oral form of ACHROMYCIN† Tetracycline . . . noted for its outstanding effectiveness against more than 50 different infections . . . and NYSTATIN . . . the antifungal specific. ACHROSTATIN V provides particularly effective therapy for those patients who are prone to monilial overgrowth during a protracted course of antibiotic treatment.

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In one state, the typical M.D. now gives away \$5,360 annually in charity medical care and cash

By John M. Morris

People are acutely conscious of the fees doctors charge. They're seldom aware of all the things doctors do for their communities with no fees attached. Now one state medical society is telling this latter story—and some of the details are surprising even to the doctors.

This month the people of Tennessee are getting new facts on how much service, money, and time their state's medical men give away. A few highlights:

¶ The typical Tennessee physician now provides more than \$4,000 worth of free medical service a year. State-wide, that's more than \$9,000,000 annually.

¶ The typical M.D. also donates \$1,360 a year to charity. That means doctors in the state give away a grand total of almost \$3,000,000 annually in cash.

¶ Finally, the typical medical man in Tennessee devotes 144 hours a year to civic projects. Examples: civil defense, fund-

h



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WHAT M.D.s DO FOR FREE

raising, Parent-Teacher Associations, Scout councils, school boards, and municipal offices.


Besides these contributions to the public welfare, the state's physicians were found to be devoting plenty of unpaid time to their own and their profession's development too. For example:

1. They're spending an average of 192 hours a year apiece to keep up with medical progress through post-graduate courses, medical-society scientific meetings, and the like.

2. They're donating an estimated \$600,000 worth of teaching time a year as unpaid faculty members in the state's medical schools.

END

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Raise the Pain Threshold

WITH **MAXIMUM SAFE ANALGESIA**

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Phenaphen with Codeine Phosphate $\frac{1}{4}$ gr. (16.2 mg.)

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Also —

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Hyoscyamine sulfate (0.031 mg.)

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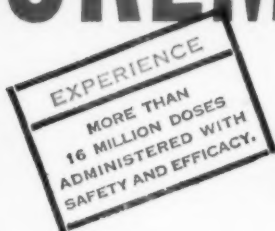
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OFFICE MANAGEMENT MEMO

From J. Hugh Clissold

*Head of the professional management
firm PM of Florida West Coast,
St. Petersburg, Fla.*



Rx for Too-Busy Offices

If your office really is too busy, you may need another aide, a new office, perhaps even an associate. But many an M.D. who needs none of these would be surprised at the way his aide inadvertently gives callers the impression that he's almost too busy to see *anyone*.

Does it happen in your office? Listen for unadorned negative statements like these: "The doctor's out at present . . . He won't be back till 3 . . . He's booked up for the next week." All these are rebuffs—"go away" answers that win you neither patients nor friends.

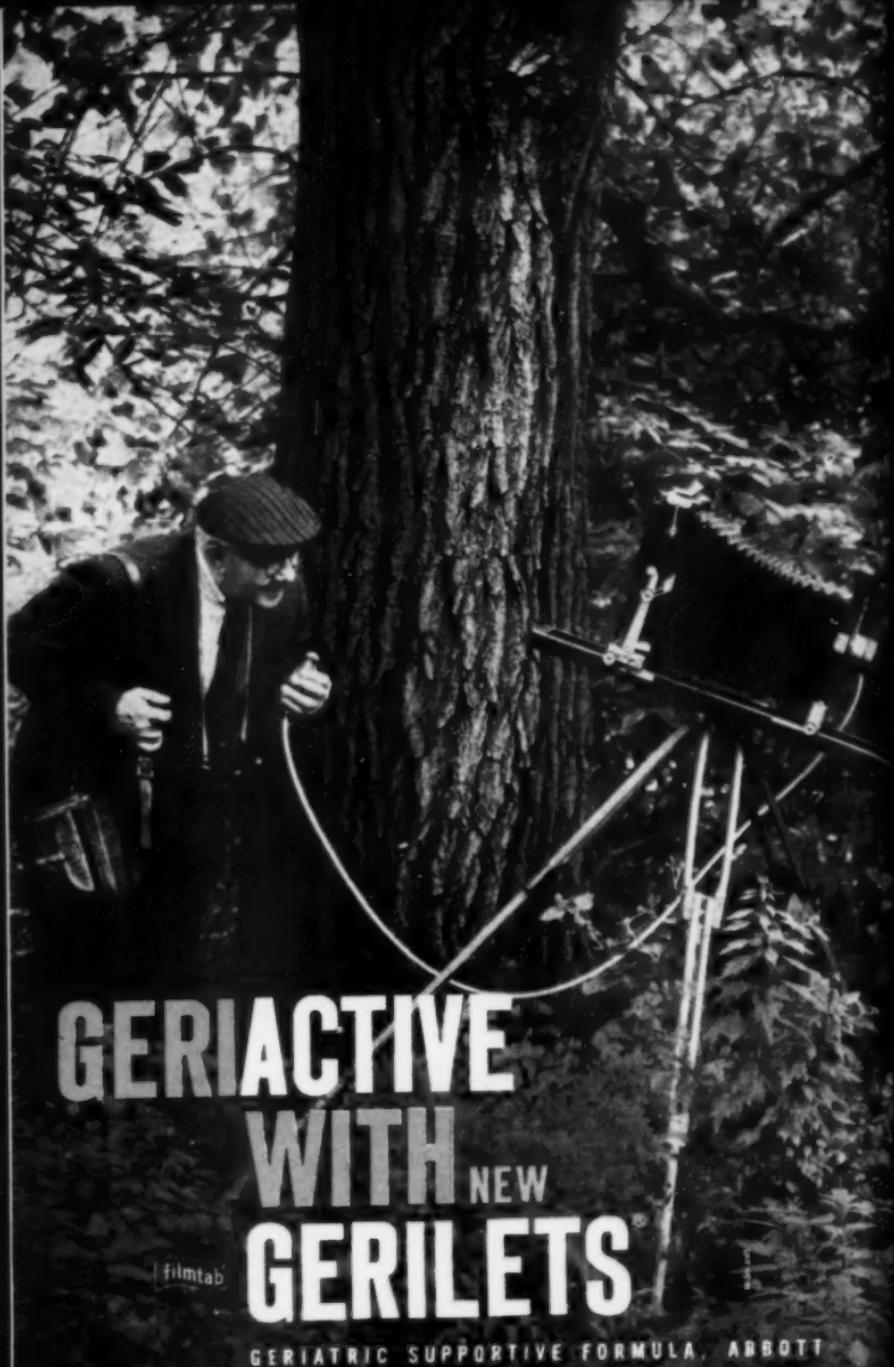
The solution? Simple. Switch these and other dismissive replies into *attractive* answers—answers aimed at bringing the patient in at some less busy time. Get your girl into the habit of saying things like:

"He'll be in the office at 3. May I ask him to call you as soon as he's able to?"

"Well, if it's an emergency, I know he'll want to see you right away. But if a week from today wouldn't seem too far off, he can give you all the time you need then."

Moral: Make it a rule in your office that no caller ever gets a flat "No."

END



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Ferrous Sulfate, U.S.P.....	75 mg.
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Ascorbic Acid.....	50 mg.
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LIPOTROPIC FACTORS

Betaine Hydrochloride.....	50 mg.
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Desoxy® Hydrochloride.....	1 mg.
<i>(Methamphetamine Hydrochloride, Abbott)</i>	

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Sulestrex®.....	0.3 mg.
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Abbott

quiets the cough
and calms the patient...

Expectorant action

Antihistaminic action

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Promethazine Expectorant, Wyeth

With Codeine

Plain (without Codeine)



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*antitussive action equivalent to that of codeine
without codeine's side-effects*

PEDIATRIC

PHENERGAN EXPECTORANT

with Dextromethorphan, Wyeth

NEW non-narcotic pediatric formula



One Way to Cope With Nonmedical 'Specialists'

The ophthalmologists are now fighting the 'pretensions' of optometry by means of their two-year-old National Medical Foundation for Eye Care. Here's how the battle is going

By R. W. Tucker



For years, such non-M.D. "specialists" as the optometrists, psychologists, and podiatrists have been staking out steadily larger claims on the fringes of medicine. Some of these practitioners seem to feel they can even supplant the physician in their respective fields. Example: The optometrists in a number of states have advocated laws designed ultimately to give them exclusive jurisdiction over eye refraction.

How can the nation's physicians keep such situations

- prompt, aggressive antibiotic action
- a reliable defense against monilia complications

both are often needed when bacterial infection occurs



for a direct strike at infection Mysteclin-V contains tetracycline phosphate complex

It provides a direct strike at all tetracycline-susceptible organisms (most pathogenic bacteria, certain rickettsias, certain large viruses, and *Endamoeba histolytica*).

It provides the new chemical form of the world's most widely prescribed broad spectrum antibiotic.

It provides unsurpassed initial blood levels — higher and faster than older forms of tetracycline — for the most rapid transport of the antibiotic to the site of infection.

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Capsules (250 mg./250,000 u.), bottles of 16 and 100.

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for protection against monilial
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Mysteclin-V contains Mycostatin

It provides the antifungal antibiotic, first tested and clinically confirmed by Squibb, with specific action against *Candida* (*Monilia*) *albicans*.

It acts to prevent the monilial overgrowth which frequently occurs whenever tetracycline or any other broad spectrum antibiotic is used.

It protects your patient against antibiotic-induced intestinal moniliasis and its complications, including vaginal and anogenital moniliasis, even potentially fatal systemic moniliasis.

MYSTECLIN-V

Squibb Tetracycline Phosphate Complex (Sumycin) and Nystatin (Mycostatin)

NONMEDICAL 'SPECIALISTS'

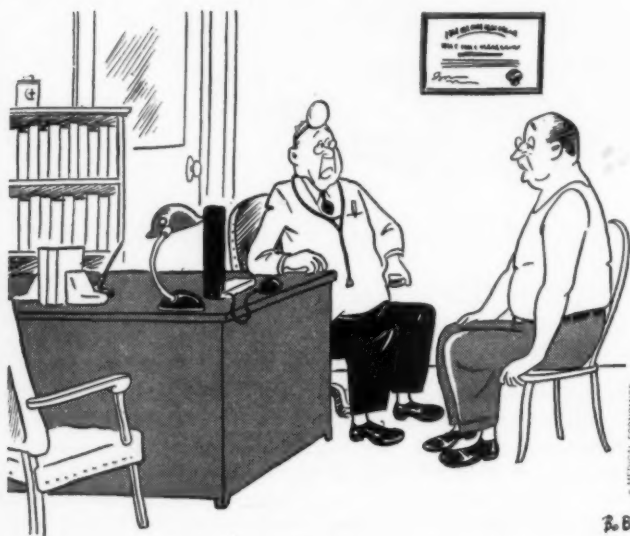
in hand? One way is to mount a vigorous counteroffensive. And that's what one medical specialty has been doing for the past two years:

In 1956, the ophthalmologists set up a National Medical Foundation for Eye Care, designed—at least in part—to fight back against “the pretensions of certain groups within optometry.” Since then, the Foundation has been conducting an active public relations campaign. Its goal: to

help laymen understand the basic characteristics of medical eye care and to impress on the lay mind the distinction between ophthalmology and optometry.

How's the battle going? The following progress report should interest every doctor who wants U.S. medical standards to remain high:

First, of course, it must be emphasized that the Foundation is opposed to “certain groups within optometry,” not to optometry



"But I'm too tired to take a vacation!"

NONMEDICAL 'SPECIALISTS'

itself. Many ophthalmologists agree that routine eye refraction can be competently handled by the optometrists (who reportedly do up to 50 per cent of all such work in this country). But the medical men see a possible danger to public health in the growing tendency of some optometrists to imply that *only* they should do refractions—and that they can be counted on to detect pathological conditions of the eye.

They Want It All

These implications seem to have been made fairly explicit in a 1954 resolution adopted by the American Optometric Association. Said the A.O.A.: "The field of visual care is the field of optometry and should be exclusively the field of optometry." And it recommended that "encroachments" into this "exclusive field" be prevented by law.

Though the optometrists later contended they were directing their fire only at unlicensed quacks, most ophthalmologists were wary of such assurances. At the A.M.A.'s 1955 meeting, the Section on Ophthalmology prevailed on the House of Delegates to adopt a number of anti-optometry resolutions. One of these declares it "unethical for any doc-

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NONMEDICAL 'SPECIALISTS'

tor of medicine to teach in any school or college of optometry, or to lecture to any optometrical organization, or to contribute scientific material to the optometric literature, or in any way to impart technical medical knowledge to nonmedical practitioners."

M.D.s Organize

It was because they felt a rising need for even more ammunition that the then leaders of the Section on Ophthalmology set up the National Medical Foundation for Eye Care. And the organization's success in attracting members indicates that many doctors believe the encroachment threat a very real one. The N.M.F.E.C., at its inception in 1956, had 600 members; today, some 2,100 M.D.s belong to it, as well as 500 nonmedical people (including many opticians).

The M.D.-figure includes about 1,700 diplomate ophthalmologists—two-fifths of the national total. But the membership isn't limited to eye men. Any physician may join for \$25 a year; and N.M.F.E.C. leaders anticipate an eventual dues-paying medical membership of 5,000.

As an opening gun in its public-education campaign, the



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Nicotinamide (niacinamide)	100 mg.
Vitamin C (ascorbic acid)	150 mg.
Vitamin A	7.5 mg. 25,000 units
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NONMEDICAL 'SPECIALISTS'

Foundation issued a leaflet called "What Is an Ophthalmologist?" During the past year, it has distributed nearly half a million copies of the leaflet. The result? Well, one result has been to make the optometrists boiling mad. After defining the ophthalmologist and the optician in simple terms, the publication proceeds to describe the optometrist as follows:

What's an Optometrist?

"An optometrist is a licensed person who has met certain legal and educational requirements and is permitted by the state to engage in the practice of optometry. He is not a physician or doctor of medicine . . . The optometrist measures the focus of the eye for glasses. He is not qualified or permitted to use drugs . . . He is not qualified or permitted to diagnose or to treat ocular disease. He may supply glasses on his own prescription. In most states he [may also] fill the ophthalmologist's prescription for glasses. By law he is a limited practitioner."

It Makes Them Boil

True? Of course. Even the optometrists can't deny it. But they're evidently angered by the implications of such a definition, as well as by the contents of an-

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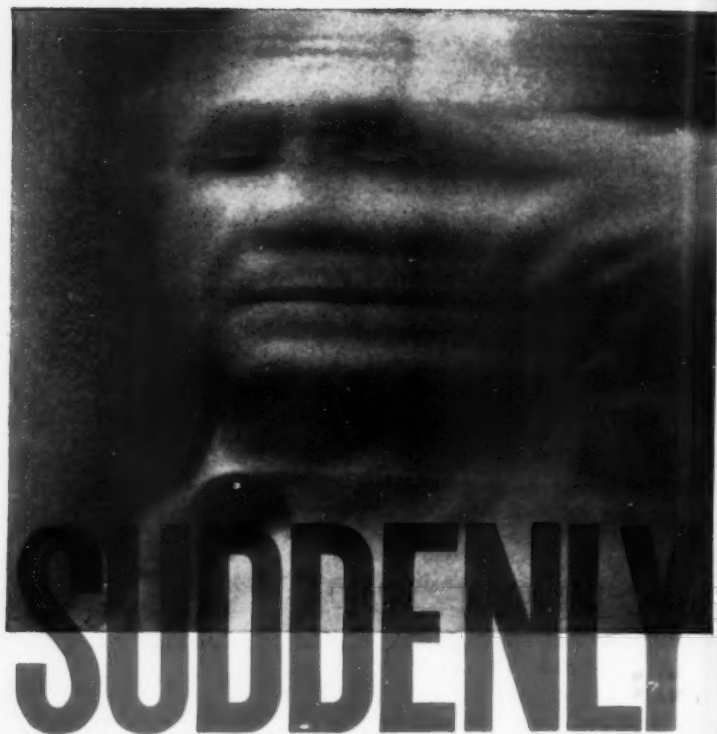
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Synkamin® (vitamin K) (as the hydrochloride)	0.5 mg.
Rutin	10 mg.
Nicotinamide	10 mg.
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Vitamin C (ascorbic acid)	50 mg.
Vitamin A	4,000 units (1.2 mg.)
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dosage: As a dietary supplement during pregnancy and throughout lactation, one or more Kapsels daily. Available in bottles of 100 and 1,000.



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*Gale, E. T., and Thewlis, M. W.: *Geriatrics* 8:80, 1953.

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NONMEDICAL 'SPECIALISTS'

other Foundation booklet, "Medicine, Optometry, and the Public Welfare." (One leading optometrist has castigated the latter as "a deliberate attempt to build up animosity and mislead the medical profession.")

The Foundation has also set up active "watchdog committees" in a number of states and in Washington, D.C., to keep a weather eye out for legislation affecting eye care. It has published a legislative guide intended to "call attention to the classic devices which have been developed over the years to confuse the lawmakers and to inflate the functions and status of optometry." It plans early distribution of a film "illustrating the rationale and technique of a medical eye examination." And it has announced that it will soon publish the results of a study of the problem of prepayment for medical eye care, along with a suggested outline for prepaid medical eye exams.

Is a War Desirable?

So it seems clear that the physicians' counterattack has been launched vigorously. Only question that troubles some medical men: Is it possible that the Foundation may be fighting *too* vigorously?

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**AMBENYL
EXPECTORANT**

for relief of coughs
due to colds
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- decongests nasal mucosa
- quiets cough reflex
- decreases bronchial spasm
- soothes irritation
- pleases the taste

per fluidounce:

Ambodryl® hydrochloride (bromodiphenhydramine hydrochloride, Parke-Davis)	24 mg.
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Dihydrocodeinone bitartrate	1½ gr.
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Potassium guaiacolsulfonate	.8 gr.
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soothes
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"a bacteriostatic bath"¹ for the oropharyngeal mucosa

Orabiotic Chewing Troches provide a unique and valuable means of symptomatic relief and specific treatment in superficial bacterial infections of the mouth and throat.

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ORABIOTIC is virtually nonirritating and nonsensitizing. These delicious cherry-flavored chewing gum troches are enjoyed by patients of all ages.

Each delicious chewing gum troche contains:

Neomycin (from sulfate)	3.5 mg.
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Propesin	
(propyl p-aminobenzoate)	2.0 mg.

DOSAGE: One troche q.i.d. chewed for 10-15 minutes.
AVAILABILITY: Packages of 10 and 20.

1. Granberry, C., and Beatrous, W.P.: E.E.N.T. Mo. 36:294 (May) 1957
2. Rittenhouse, E.A.: E.E.N.T. Mo. 36:406 (July) 1957.
3. Fox, S.L.: Clin. Med. 4:699 (June) 1957.



WHITE LABORATORIES, INC., Kenilworth, New Jersey

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NONMEDICAL 'SPECIALISTS'

A few observers have warned that a really bitter quarrel with non-M.D. "specialists" is bound to result in an upsurge of ill will. They fear that resentment against the medical profession can spread from the optometrist to the podiatrist to the psychologist—and eventually to the public.

Optometrists Fight Back

Certainly, the American Optometric Association isn't turning its other cheek to the Foundation's blows. In a recently published article, Optometrist Carel C. Koch characterized the N.M. F.E.C. as "a poorly disguised effort to secure more patients for ophthalmologists and opticians at the expense of optometry." Calling the Foundation's members "splinter-group" doctors, he accused them of wanting "to adversely affect the interprofessional relations between optometry and ophthalmology as much as they can." And his own Association, of course, is busy preparing its own patient-directed leaflets.

Thus, a number of physicians fear that bad feeling could easily snowball. So they're keeping their fingers crossed about the outcome. Witness the following comment from Dr. William Benedict, secretary-treasurer of the



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NONMEDICAL 'SPECIALISTS'

American Academy of Ophthalmology and Otolaryngology:

"Most optometrists are agreeable, law-abiding people. But within their organizations they let public relations men and lawyers make resolutions for them. Later they have to explain their intentions as best they can. Now the ophthalmologists are doing the same thing. I don't see how any good can come of it."

'Efforts May Boomerang'

Warns another well-known eye man: "The N.M.F.E.C.'s efforts may well boomerang. We depend on optometrists more than most of us like to admit. Can we really afford to alienate them? There's no law that says they have to send us patients. And it isn't just our pocketbooks that'll suffer if they stop referring people to us. It's the patients too."

But spokesmen for the Foundation maintain that such fears are unwarranted. They point out that the Foundation has the support of most past and present leaders of the American Academy of Ophthalmology and Otolaryngology. And they insist their organization's efforts have already borne good fruit. As one

proof of their point, they cite a recent statement from Lester A. Sugarman, president of the American Optometric Association. Said he:

What They Don't Want

"We do not seek to 'enter medicine by the back door.' Medicine has been misinformed about us . . . Many physicians believe that official optometry at the national level has sought and seeks legislation prohibiting or limiting medical refraction, or permitting optometrists to prescribe for disease. We . . . can truthfully say that some unwise attempts have been made by individuals, but not with A.O.A. approval."

Cooperation Invited

Whether or not that statement signals a retreat, a number of ophthalmologists have commented on its markedly different tone from optometrist pronouncements of a few years ago. Says one physician: "If that's really their attitude now, I'd say the N.M.F.E.C. has proved its mettle. After all, we're not out to 'get' the optometrists. We'll be glad to work *with* them for the good of all our patients." END

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"In diagnosis and treatment [of cardiovascular diseases]... the physician must deal with both the emotional and physical components of the problem simultaneously."¹

The addition of Miltown to PETN, as in Miltrate, "...appears to be more effective than [PETN] alone in the control of coronary insufficiency and angina pectoris."²

Miltrate is recommended for prevention of angina attacks, not for relief of acute attacks.

Supplied: Bottles of 50 tablets.

Each tablet contains: 200 mg. Miltown + 10 mg. pentaerythritol tetranitrate.

Usual dosage: 1 or 2 tablets q.i.d. before meals and at bedtime.

Dosage should be individualized.

For clinical supply and literature, write Dept. 3J

1. Friedlander, H. S.: The role of ataraxia in cardiology. *Am. J. Card.* 1:395, March 1958.

2. Shapiro, S.: Observations on the use of meprobamate in cardiovascular disorders. *Angiology* 8:504, Dec. 1957.



WALLACE LABORATORIES, New Brunswick, N. J.

*TRADE-MARK



TAKE A LESSON FROM

22. *The Case of* the

By Xavier F. Warren

EDITOR'S NOTE: *Here's the twenty-second in a series of true incidents selected from the confidential file of a malpractice insurance company's claims adjuster. Although names and identifying details have been changed, the stories accurately portray recent cases.*

You know how hard it is to help a patient who isn't frank with you about the facts related to his illness. Well, we claims adjusters sometimes have the same sort of trouble with a doctor we're trying to help. Through pride or misguided caution, he'll withhold from his own malpractice defense team some fact he thinks might damage his case. By doing so, he simply digs a pit for himself to fall into.

Such a doctor was G. Bennett Ashforth. He was a prominent psychoanalyst who, though an M.D., didn't believe in giving the patient a physical examination himself. To do so, he held, was to contaminate the psychotherapy. He put every new patient through a thoroughgoing *mental* examination, including psychological tests. But no *medical* examination. He figured that was the family doctor's job.

One day Mrs. Robert Stone, an attractive 32-year-old

ROM THESE MALPRACTICE MISHAPS!

of *the Disingenuous Doctor*

commercial artist, came to Dr. Ashforth complaining of frequent headaches and inability to concentrate. The doctor, as was his wont, gave Mrs. Stone a preliminary mental examination lasting several hours. This indicated she was sufficiently intelligent, sincere, and mature to profit by psychoanalysis. So she became his patient.

After some months of psychotherapy, she showed no improvement. Then suddenly her condition became worse. Her husband took her to a neurologist. His immediate diagnosis: a brain tumor. Within three weeks, she was dead.

Soon after, the husband filed a malpractice suit against Dr. Ashforth. From first reports, the case didn't look too tough to defend. Nevertheless, the home office sent me down to see Dr. Ashforth right away.

In the course of our talk, I said: "Now, Doctor, I assume you gave Mrs. Stone a thorough examination before accepting her for analysis?"

"Yes," he replied. "A most thorough examination. It took me several hours."

Of course, I assumed he meant a physical examination. The doctor did nothing to enlighten me. And a bit

THE DISINGENUOUS DOCTOR

later, I sat in while two M.D.s from the county medical society's malpractice defense committee talked with Dr. Ashforth about the case. One of them asked him: "In your examination of Mrs. Stone, did you do an ophthalmoscopy?"

"No ophthalmoscopy but all the usual tests," the psychoanalyst answered firmly.

"And you found no increased intracranial pressure—nothing to indicate the condition the patient eventually died of?"

"No," said Dr. Ashforth.

Our attorneys prepared a defense accordingly. And it caved in completely when, on the witness stand, Dr. Ashforth was forced by the plaintiff's attorney to admit he'd given the patient no physical examination whatsoever. That won the case for the plaintiff then and there. The jury's award: \$60,000.

If only Dr. Ashforth had been candid with us, we could have saved him and his colleagues a lot of money. Knowing the local facts, we might have settled the case before trial—for something well under what the jury awarded. Or, if we'd decided to fight it out in court anyway, we'd have organized our defense differently. For example, we could have taken the position that it's not a psychotherapist's function to treat physical disorders, hence he shouldn't be expected to diagnose them.

As it was, our defense rested on a false assumption that was easily knocked down. We'd assumed that Dr. Ashforth had examined the patient and found nothing wrong. And the doctor had not corrected us.

That's the sign of a disingenuous doctor, than which there is nothing harder to defend. END

Collector's Item

My new secretary had been a patient of mine. A few weeks after starting the job, she was summoned before a local magistrate. Seems that in turning over delinquent accounts to a collection agency, she'd absent-mindedly included her own.

—MERLE S. SCHERR, M.D.



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tenseness
out

BUTISOL[®]

sodium
butobarbital sodium

TABLETS • REPEAT-ACTION TABLETS • ELIXIR • CAPSULES

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without substituting
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BUTISOL[®] has a known and predictable action—small daily dosage “will produce satisfactory daytime sedation... with minimal occurrence of untoward reactions.”¹

With BUTISOL there is no personality distortion or indifference to responsibilities.

1. Grossman, A. J., Batterman, R. C., and Leifer, P.: Fed. Proc. 17:373 (March) 1958.



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the chill

the cough

the aching muscles

the fever



Viral upper respiratory infection. . . . For this patient, your management will be twofold—prompt symptomatic relief plus the prevention and treatment of bacterial complications. **PEN·VEE·Cidin** backs your attack by broad, multiple action. It relieves aches and pains, and reduces fever. It counters depression and fatigue. It alleviates cough. It calms the emotional unrest. And it dependably combats bacterial invasion because it is the only preparation of its kind to contain penicillin V.



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Philadelphia 1, Pa.

Political Campaign Ranges From Teeth to Tonsil Snatching



'Ole Doc' Knox

BY JOHN M. MORRIS

"Vote for Good Ole Doc Knox for Congress . . . Pledged to investigate the drug companies and those in the American Medical and Dental Associations who are holding up the health of the country."

Washington State voters have been hearing a lot about "Ole Doc" Knox. He's actually a 34-year-old dentist, Dr. Eugene J. Knox, whose first attempt to win public office has strongly resembled an old-fashioned medi-

cine show. His campaign literature identifies him as "a scientist, medical and dental researchist, author, proponent of common sense and practical Americanism." It adds modestly: "Doc Knox solved the perplexing problem of gum disease which caused the loss of most teeth. Many physicians believe that he might have the answer to cancer and heart disease."

These physicians' faith in him is apparently not reciprocated;

fast

welcome relief of spasm and pain is continuously reported in functional G-I disorders, such as irritable, spastic colon syndrome; peptic ulcer; biliary dyskinesia; pylorospasm; and infant colic.

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relief can be expected . . . even in patients where other antispasmodics have failed.¹⁻³

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dual antispasmodic action is specific to the G-I tract. Spasm pain is relieved by direct relaxation of the smooth muscle and postganglionic parasympathetic nerve blockage.

safe

even in the presence of glaucoma⁴ . . . BENTYL does not increase intraocular tension, produce blurred vision, dry mouth or urinary retention.

relief of g-i spasm & pain Bentyl

20 mg. t.i.d. (dicyclomine) Hydrochloride

1. Chamberlain, D. T.: *Gastroenterology* 17:224, 1951. 2. Hoch, C. W.: *J. N. A. G.* 49:124, 1951. 3. Derome L.: *Canad. M. A. J.* 69:532, 1953. 4. Cholat, M., Goodstein, S., Beres, G., and Ciootti, A.: *J. A. M. A.* 166:1576, 1956.



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POLITICAL CAMPAIGN

in fact, Candidate Knox has some very pointed things to say about the way medicine is practiced. For instance, in one speech he asserted:

"I claim the medical profession is responsible for killing more people than they save. The stupidities of the American Medical Association are responsible for millions of cripples. By emphasis on cure instead of pre-

vention, they have been responsible for withholding twenty to thirty years of life expectancy from the American people."

After a few campaign speeches like these, Knox discovered that he lacked support from physicians in his district. The main reason, he thought, may have been that he'd "demanded they cease their tonsil snatching." But if his influence in local medical



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"... transfusion reaction ... claims I gave him 'tired blood'..."



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this was the
symbol for life.*



In pharmaceutical
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symbol means there's
a comprehensive
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product in your copy
of PHYSICIANS'
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POLITICAL CAMPAIGN

circles wasn't much, at least he could point to his influence in White House medical matters.

Early this year, as he tells it, he tired of reading of President Eisenhower's persistent cough and so he went to the White House to persuade the Chief Executive to have a dental examination. On the way, he dropped by Walter Reed Hospital to criticize the dental staff "for not examining the President, when heart disease and dental infection [are] tied hand-in-hand." Then, he recounts, "I saw James Hagerty . . . Three days later Ike had a tooth removed. It had been split in his mouth for months, and could readily have been responsible for his ailments."

Perhaps unfortunately for our National Government, Knox won't be part of it next year. He ran last in a field of three in the Democratic primary election last month.

END



when nausea and vomiting
bring a plea for help . . .

suggest first aid with . . .

EMETROL®

[PHOSPHORATED CARBOHYDRATE SOLUTION]

a safe, pleasant-tasting, oral antiemetic . . .

effective in 6 out of 7 cases of functional vomiting¹—often associated with intestinal “flu” or G.I. gripe. Rapidly effective . . . economical . . . and *safe physiologic action* usually eliminates need for potentially hazardous antiemetic drugs. Also established for safe relief of “morning sickness.”²

Dose: children, 1 or 2 tsp.; adults, 1 or 2 tbsp.; repeat every 15 minutes until vomiting ceases. In bottles of 3 and 16 fl.oz. **DO NOT DILUTE.**

¹J. Bradley, J. E., et al.: *J. Pediat.* 39:41, 1951. ²Crunden, A. B., Jr., and Davis, W. A.: *Am. J. Obst. & Gynec.* 65:311, 1953.



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Tao *
PRONOUNCED TAY-O

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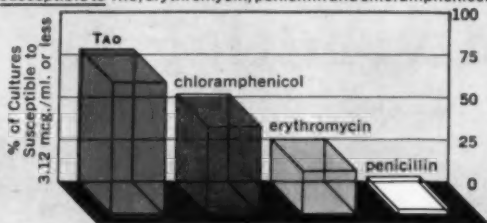
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CLINICAL RESULTS	adults	children	all Staph infections
Cured	172 (80%)	148 (89%)	71 (88%)
Improved	28 (13%)	8 (5%)	7 (9%)
Failure	17 (7%)	11 (6%)	3 (3%)

Types of infecting organisms: The majority of identified etiologic microorganisms were *Staph. aureus* and *Staph. albus*. *Tao* has its greatest usefulness against the common infections caused by organisms such as: staphylococci (including strains resistant to other antibiotics), streptococci (beta-hemolytic strains, alpha-hemolytic strains and enterococci), pneumococci, gonococci, *Hemophilus influenzae*.

Per cent of "antibiotic-resistant" epidemic staphylococci cultures susceptible to *Tao*, erythromycin, penicillin and chloramphenicol.



REACTIONS:

(a) adults

Total—9.2% (20 out of 217)
 Skin rash—1.4% (3 out of 217)
 Gastrointestinal—7.8% (17 out of 217)

(b) children

Total—0.6% (1 out of 167)
 Skin rash—none
 Gastrointestinal—0.6% (1 out of 167)

There was complete freedom from adverse reactions in 94.5% of all patients. Side effects in the other 5.5% were usually mild and seldom required discontinuance of therapy.

stability in gastric acid • rapid, high and sustained blood levels • high urinary concentrations • outstanding palatability in a liquid preparation

Dosage and Administration: Dosage varies according to the severity of the infection. For adults, the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. For children 8 months to 8 years of age, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective.

Since *Tao* is therapeutically stable in gastric acid, it may be administered without regard to meals.

Supplied: *Tao* Capsules—250 mg. and 125 mg.; bottles of 60. *Tao* for Oral Suspension—1.5 Gm.; 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. English, A. R., and Fink, F. C.: *Antibiotics & Chemother.* (Aug.) 1958. 2. English, A. R., and McBride, T. J.: *Antibiotics & Chemother.* (Aug.) 1958. 3. Wennersten, J. R.: *Antibiotic Med. & Clin. Therapy* (Aug.) 1958. 4. Celmer, W. D., et al.: *Antibiotics Annual 1957-1958*, New York, Medical Encyclopedia, Inc., 1958, p. 476.

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Dosage range 2-10 mg.

Intramuscular: 15 mg. average single dose

Dosage range 5-15 mg.

If subsequent parenteral dose is needed, one-half the original dose will usually suffice

Oral: 10-20 mg. initially; then 10 mg. t.i.d.

SUPPLY:

Parenteral solution - 1 cc. ampuls (20mg./cc.),

1 cc. multiple dose vials (20 mg./cc.)

Oral tablets - 10 mg., 25 mg., 50 mg., in bottles of 50 and 500

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Federal Disability Reports Aren't Too Tough After All

Doctors are encountering some headaches—but fewer than expected—in reporting on patients applying for Federal disability benefits

By Ethel J. Swing

It's two years since Congress handed the nation's doctors what looked like a very hot potato. Social Security benefits were extended to the disabled at age 50 instead of at age 65. And how would people qualify for these earlier benefits? They'd have to get disability reports filled out—by their doctors, of course.

This led to an entirely logical forecast for physicians: more red tape, more physical exams, more

disputed claims, maybe even an occasional summons into court. But it hasn't worked out that way. It hasn't been that bad because:

¶ No doctor has had to re-examine a long-disabled patient just to satisfy the law. At first, some physicians protested: "I haven't examined the patient in years. How can I report his present condition?" The Government's reply: "Don't. Report on

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Dosage: The recommended adult dose is 1 Gm. (2 tablets) the first day, followed by 0.5 Gm. (1 tablet) every day thereafter, or 1 Gm. every other day for mild to moderate infections. In severe infections where prompt, high blood levels are indicated, the initial dose should be 2 Gm. followed by 0.5 Gm. every 24 hours.

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references:

1. Griebble, H. G., and Jackson, G. G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958.
2. Editorial: *New England J. Med.* 258:48-49, 1958.

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^{*}Reg. U.S. Pat. Off.

FEDERAL DISABILITY REPORTS

his condition as of the time you last examined him." The disability report form turned out to need substantially nothing more than an abstract of the patient's past medical record.

¶ No doctor has been haled into court. Under the law, court reviews of disability findings are based only on the written report.

At the end of the program's first year, the Government was paying disability benefits to 200,000 persons—and had denied benefits to another 200,000. For 150,000 of these denials, medical factors were responsible. Doubtless this has put some doctors on the spot.

When patients argue about rejected disability claims, what's the doctor supposed to do? This, according to Government officials:

"Emphasize to the patient that

you're reporting medical findings only," they advise. "Explain that you cannot pass on whether he's disabled within the meaning of the Social Security law."

Both the arguments and the report writing should be less of a problem pretty soon, the same officials say. Reason: The total number of applications processed so far is an abnormal figure, they insist. It represents a backlog that's been accumulating since 1941.

A new flood of cases is expected as a result of amendments to the Social Security Act made this year. But officials say that the day is not far off when only new disability cases will be coming up. For doctors, this'll mean (1) considerably fewer reports and (2) an end to the business of digging out fifteen-year-old records.

END

Second Choice

The 3-year-old had just had an abdominal operation. He kept asking tearfully for a drink of water. Finally, in desperation, the nurse explained to him he couldn't have water because "the plumber is fixing your pipes."

"O.K.," he said pathetically. "Can I have some beer?"

—ELIZABETH GROVE, R.N.



The new curbs on civilian care of military dependents will mean fewer Medicare patients for some doctors, concede Medicare's two top directors. But the drop-off may be less than many medical men predict. And doctors themselves probably helped make the restrictions necessary. You'll see why in this exclusive interview with . . .



Dr. Frank Berry, Asst. Secy. of Defense (Health and Medical),



and Col. Floyd Wergeland, Medicare's new executive director

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What You Can Expect From Medicare

By Robert L. Brenner

"Medicare has been wrecked!" . . . "Military dependents have lost their free choice of physician" . . . "Doctors near military posts will see their Medicare patient-load evaporate" . . . "The cuts Congress made in Medicare's appropriation mean the whole program will be scuttled next spring!"

Dire predictions like these have been coming from throughout the medical profession in recent weeks. They were touched off by two things that happened to the Dependents Medical Care program this summer: (1) Congress ordered the Defense Department to spend some \$30,000,000 less on Medicare this fiscal year than the program cost for services provided during fiscal '58; and (2) the Defense Department responded by ordering sharp cuts in the amount of civil-

ian care military dependents henceforth may get.

How justified is the widespread concern over Medicare's future? To find out, I recently flew to Washington to interview the two men best qualified to know: Dr. Frank B. Berry, Assistant Secretary of Defense (Health and Medical), who helped write the new Medicare regulations; and Col. Floyd L. Wergeland, Medicare's new executive director, who's responsible to Dr. Berry for seeing that the new regulations are carried out.

In brief, these two top officials told me:

¶ The program hasn't been wrecked; it's been curtailed. Medicare will no longer pay for some types of care. And dependents who live with their sponsor now must use *military medical*

WHAT YOU CAN EXPECT FROM MEDICARE

facilities whenever available instead of getting civilian care.

¶ It's true that these dependents will lose their free choice of physician in some cases. But there was no other practical way to achieve the cost cutbacks Congress ordered.

¶ It's also true that doctors near some military posts will get fewer Medicare patients. Nation-wide, civilian doctors may get up to 40 per cent fewer Medicare maternity cases, and 10 to 20 per cent fewer medical and surgical cases.


¶ Despite the cuts in Medi-

care's appropriation, it's unlikely the program will fold next spring. It's unlikely, that is, if everyone concerned tries to hold the line on costs—which is what the Congress wants.

This is only a brief summary of what I was told in Washington. To give you a better idea of what you can expect from Medicare in coming months, here's a detailed account of our discussion:

Dr. Berry led off. "Before we discuss how the new Medicare regulations will affect doctors," he said, "let's be sure there's no

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(Marks, M. M.: Clin. Med. 4:151, 1957)

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WHAT YOU CAN EXPECT FROM MEDICARE

confusion about just what the new regulations are." Col. Wergeland handed me a copy. As I scanned it, the colonel asked me to note: "The changes we've made fall into two categories. First, Medicare will no longer pay civilian doctors for some of the treatments it formerly covered.

I saw that this "discontinued" list included such care as:

¶ Out-patient care other than in maternity cases.

¶ Post-natal visits on an out-patient basis.

¶ A physician's terminal visit

prior to hospitalizing a patient.

¶ Treatment of emotional disorders (except during Medicare-covered hospitalization).

¶ Elective surgery.

(As before, payment isn't authorized, either, for treatment of chronic disease or for domiciliary care, ambulance service, and medical supports or aids.)

More Restrictions

"These restrictions apply to all dependents," Col. Wergeland explained. "In addition, the Secretary of Defense has further restricted the civilian care of those



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dependents who live with their sponsors.

"Before such a dependent can get Government-paid treatment from a civilian doctor, she now must get a permit from her sponsor's commanding officer certifying that military facilities to treat her are not available. And we will be unable to pay the bill of any doctor who treats such a dependent unless that permit is attached to it—except in emergency cases."

"Doesn't that take away these dependents' free choice of physician?" I asked.

"Yes, it does," Dr. Berry answered. "And we didn't like to do it. But it was the only way we could find to carry out Congress' orders. To see why, you've got to understand what the Congress instructed us to do.

An Economy Move

"Congress ordered us to keep Medicare's cost down to about \$72,000,000 this fiscal year. Before restrictions could be placed in effect, we were already three months within the fiscal year. We quickly worked out detailed plans for proposed econo-



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WHAT YOU CAN EXPECT FROM MEDICARE

mies and presented them to members of the Appropriations Committee. We all agree that what we're doing should meet the desire of Congress that we make the fullest possible use of military hospitals."

"How much more of a load can the existing military medical facilities handle?" I asked Col. Wergeland.

"We don't know yet," the colonel said. "To find out, the commander of each military medical facility in the country has been asked for a detailed estimate for his installation."

"Those estimates should give a pretty good picture of how much the civilian doctor's Medicare patient-load is going to drop," I said.

"They should," Col. Wergeland agreed, "when we get them all tabulated. All we have to go on right now are preliminary estimates the Armed Forces gave us earlier."

"What do *they* indicate?"

"We think civilian doctors nation-wide may get up to 40 per cent fewer Medicare maternity cases. And they may see 10 or 20 per cent fewer surgical and



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medical cases of other kinds. But let me emphasize that this is just the roughest kind of guess, since we haven't yet tabulated the commanders' detailed reports.

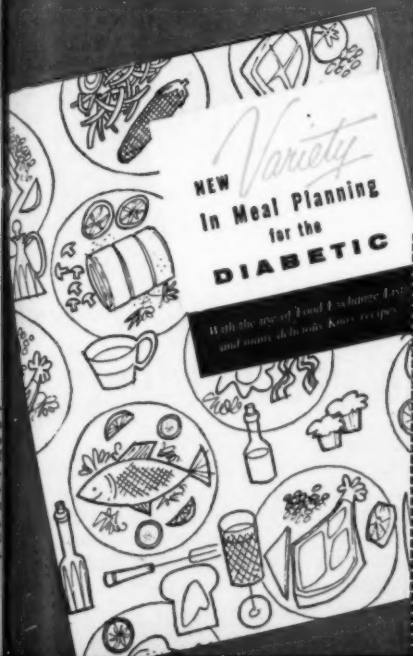
"Let me emphasize too," the colonel went on, "that the civilian-care drop-off will differ with each military post. Doctors near a post whose hospital is already working near full capacity will see little change in their Medicare patient-load. Doctors near military hospitals that have been operating at half capacity may get considerably fewer Medicare patients."

There was one more thing I wanted to find out. "Do you think that with these restrictions, Medicare will operate within the \$72,000,000 limit Congress set?" I asked Dr. Berry. His answer was surprising:

"No," he said. "Even with the new restrictions, we expect to run some \$12,000,000 over the limit Congress set."

"Then does that mean Medicare will have to be discontinued when the limit is passed sometime next spring?"

"We hope not," Dr. Berry said. "We believe Congress will



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WHAT YOU CAN EXPECT FROM MEDICARE

grant us additional funds when the present appropriation is used up. And here's why we think so:

"I'm sure it's not Congress' intention to scuttle Medicare. Not now, not next spring, not in the foreseeable future. They do intend to pare down the program's cost. But if we convince them that despite honest efforts to economize, Medicare still can't run on \$72,000,000, we feel certain they'll grant us additional funds.

"That *if* is a big one, though," Dr. Berry went on. "Because Congress won't give us any addi-

tional funds unless they're sure we *did* try to economize. And to convince them of that, we're going to need the help of every doctor who treats a Medicare patient."

He Blames Doctors

Dr. Berry paused. Then he said: "We'll need that help because doctors themselves are partly responsible for Medicare's present overly high cost. Let me tell you why:

"Before I worked for the Government, I practiced privately for thirty years," he said. "I've



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treated patients under Blue Shield, under private insurance plans, and under Workmen's Compensation. And I know that when the health plan has a fee schedule, it's awfully tempting for a doctor to forget his usual charge and simply demand the top fee allowable."

Dr. Berry picked up a letter from his desk. "A Medicare patient wrote me this," he said. "She's the wife of a coastguardman. I'll read you part of what she says:

"We received an anesthetist's bill for \$15 for our daughter's

tonsillectomy,' she writes. 'So I called his office to request that the bill be sent to Medicare. When his receptionist heard "Medicare," she told me to destroy the bill. "We always charge Medicare the top fee," the girl explained. And I've got three other such bills from doctors that I've been asked to destroy.'

Medicare Victimized

"The fee Medicare will pay that anesthetist is \$25," Dr. Berry said. "So he's actually overcharging us \$10."

Col. Wergeland broke in:



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WHAT YOU CAN EXPECT FROM MEDICARE

"We have some evidence that there's a widespread tendency to charge the maximum fee scheduled. For instance, there are ten states in which Medicare's fee schedule isn't generally made known to physicians. And those physicians' bills to us generally run considerably lower than in states where physicians know what the top limit is."

I thought about this for a while. Then I asked: "Dr. Berry, would you say the success or failure of Medicare now depends on

how well individual doctors cooperate in holding down the program's costs?"

Dr. Berry smiled. "Well, I will say this: If we're to convince Congress next spring that Medicare honestly deserves more funds, we'll have to show them that the cost-cutting effort is being shared by everyone concerned with the program—military dependents, Medicare officials, *and* doctors. If we can do that, I feel sure Congress won't scuttle the program." END



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"She wants to know if she should boil the water for an enema when she travels in Mexico."



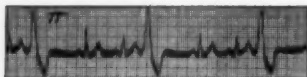
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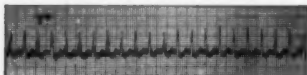
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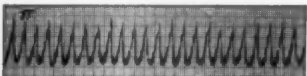
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REFERENCES: 1. Miller, R. F.: Clinical Review, Vol. 1, No. 2 (July) 1958. 2. Van Gasse, J. J.: Clinical Medicine, 5:177-181 (Feb.) 1958. 3. Burrell, Z. L., et al.: Am. J. Cardiol., 1:624 (May) 1958. 4. Hutcheon, D. E., et al.: J. Pharmacol. & Exper. Therap., 118:461 (Dec.) 1956.

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Why Doctors LEAVE Group Practice



This poll of men who've quit groups suggests that too many big, booming organizations are likely to be afflicted with 'commercialism, factionalism, favoritism, and know-nothingism'

By G. Gordon McHardy, M.D.

Not long ago, I put a straightforward question to a hundred-odd doctors who have resigned from the group practices to which they once belonged: "Why did you quit?" Their answers really gave me something to think about.

I was struck by the fact that a significant number of the men emphasized that they hadn't found fault with group practice as such, but with *big* groups. That's an interesting

THE AUTHOR, a New Orleans gastroenterologist, is immediate past president of the American Association of Medical Clinics. He's also a senior partner of the Browne-McHardy Clinic, a nineteen-man group practice.

WHY DOCTORS LEAVE GROUP PRACTICE

finding, since there's been a lot of talk lately about a trend toward large clinics in this country. (For example, see A.M.A. President Gunnar Gundersen's remarks on this subject in "Groups Give Patients More for Their Money," MEDICAL ECONOMICS, May 26, 1958.)

What seems to be the trouble with many big, successful organizations? My survey indicates that there are four main reasons why some doctors aren't happy in them. Such clinics are apparently more likely than smaller ones to succumb to one or more of the following "isms": commercialism, factionalism, favoritism, and know-nothingism.

To see the picture more clearly, let's review some typical comments from the queried physicians. Here's why they say they got fed up with the groups they once belonged to:

1. They disliked the commercialism. A common complaint appears to be that the large clinic doesn't always permit its members to establish a proper doctor-patient relationship. And one alleged reason for this failure is that many a group becomes so mechanized and

money-conscious that it concentrates on business rather than on medicine.

Says a Western G.P., for example: "In the group I was associated with, there's a very poor doctor-patient relationship. The doctor has no sense of continuity. He loses his proper relation to the patient and becomes a servicer much like a radio repairman. Many patients have to see unfamiliar doctors at the most crucial times—e.g., night emergencies. Conversely, the doctor feels little compulsion to dash out to visit an unknown patient in the early morning hours."

Another Western generalist remarks: "I quit my clinic because (1) I was given an inadequate ten to fifteen minutes to examine and treat a patient; and (2) I could never develop a real doctor-patient relationship because I couldn't follow seriously ill patients through to the conclusion of their diseases."

Observes a Southern internist: "The more successful a clinic becomes, the less able it is to fulfill its original mission of supplying expert medical care. As a group grows, an increasing amount of work must be done by people still, so to speak, in the training

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Allergic reactions



WHY DOCTORS LEAVE GROUP PRACTICE

stage. The consultants one respects are too busy.

"I found that whenever I referred patients to other departments in the group, the telephone operator at the appointment desk was deciding whom to send them to. Such decisions weren't made on the basis of who was most competent, but on the basis of who was most available."

And an Eastern specialist in pulmonary diseases says: "Like most physicians joining a group, I wanted to practice the best kind of medicine and to have all the details of billing and business taken care of for me. I wanted

the patient to get the benefit of such organization too. But as the organization grew larger and as its gross income went up, the doctors and their departments became more and more concerned with their contributions to and their shares in the group income. Good medicine took a back seat to commercial competition."

2. They disliked the factionalism. To put it another way, many of the disillusioned doctors complain that the policies of their groups were set exclusively by ingrown cliques. Some of the men I queried say they were



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^{*} S. J. Clark, F. J. Jennings, M. J. Pollack, F. J. Olson, M. J. West, L.

W. J. West J. Surg. 64, 152, 1956.

Delfen: Nonylphenoxypolyoxyethyleneol 5% in an oil-in-water emulsion of all oils.

WHY DOCTORS LEAVE GROUP PRACTICE

treated as members of lightly regarded specialties. Others seem to have felt like permanent junior men, whom the senior partners were bent on excluding from any real voice in group decisions.

'Stepchild' Department

A Western otolaryngologist tells this sad story: "The clinic's department of ophthalmology and otolaryngology was considered a stepchild, and its members were considered slightly lower than morons. Technical procedures rightfully belonging to our department were often shunted into the departments of general medicine or general surgery. So my associates and I were made to feel we weren't part of a working organization."

'Surgically Dominated'

Reports a Midwestern internist: "Quite frankly, I left the clinic because it was surgically dominated. I believe that group practice in the future must recognize the merits of all specialties and must give recognition to men on the basis of training, seniority, contribution to group growth, and other factors besides dollar return. I believe those groups that are controlled by small

cliques, or set up primarily for the convenience of surgeons, inevitably face a high rate of personnel turnover."

A Southwestern pediatrician declares: "The clinic staff never had a voice in the operation of our clinic. All decisions were made by the few men who were on the board of trustees. This board was a self-elected, self-perpetuating body that had held office year after year without change."

He Prefers Small Groups

Adds another Southwestern pediatrician: "My reason for leaving was primarily to escape a feeling of being a relatively minor employe of a large, established group." But he points out that he has no quarrel with group practice as such. In fact, he has now joined a much smaller organization, where "I'm a full, equal partner and head of my own department, which I organized."

He's by no means the only man who has quit a big group only to join a small one. Reports a Southern surgeon who has made the switch: "I feel that the advantages of a small group far outweigh those of a big one. In our

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WHY DOCTORS LEAVE GROUP PRACTICE

small group, the daily contacts among all members are intimate and satisfactory, both professionally and otherwise. Administrative matters can be frankly discussed and decisions arrived at by all concerned, not by some special committee."

3. They disliked the favoritism in financial matters. Only a rare doctor says he quit group practice because he wasn't earning enough. But many of the men say they cut loose because they had little or no hope of earning substantially more. Or else they were made to feel financially insecure.

As one Westerner puts it: "Although my salary was satisfactory, the particular clinic for which I worked had no plan by which an employee could buy stock or become part-owner in the organization. After five years with the clinic, I was convinced that I had reached my peak, both professionally and financially."

Adds a Western OB/Gyn. man: "After five years, my gross income rated fifth highest in the clinic; yet my salary was only eighteenth highest. The clinic provided advantages for a select

few. There was no insurance or retirement plan, even though the clinic had been expanding for twenty-five years. We were told it had never arrived at a point where it could afford to inaugurate such a program. I bet it still hasn't."

A Midwestern internist asserts: "I'd always felt I'd get a feeling of security from being a member of a group. But the opposite seemed to be true. There were three widely varying age groups in the organization, with considerable tugging and hauling—e.g., pressure from the younger men for more money, pressure from the older men to keep what they had. I had no particular complaints about my stipend. But there was such constant talk about changing the method of distributing income that I never felt one particular method was assured."

4. They disliked the "know-nothingism." For one reason or another, some large groups seem to discourage scientific endeavor. At least one doctor insists that outside clinical activities were actually forbidden by his group.

Comments a Southern internist: "No amount of scientific

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Composition: Each tablet contains 400 mg. meprobamate and 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl).

Supplied: Bottles of 50 scored tablets.

†TRADE-MARK CO-7470

1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958.

2. Current personal communications; in the files of Wallace Laboratories.

Literature and samples on request



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WHY DOCTORS LEAVE GROUP PRACTICE

veneer can gloss over the commercial core of a large clinic. The urge to pay the overhead destroys any stimulus to create an atmosphere of intellectual curiosity. So it becomes impossible to develop training programs that even approach those offered by universities."

And here's what a Midwestern dermatologist has to say: "I was interested in doing more active teaching at a university, but any such association was frowned on by most members of the group. During the first two years I was attached to it, I made a weekly trip to a near-by city to teach in a university clinic. Finally, I was formally prohibited from doing so."

As I've pointed out, few of the men I queried are opposed to

group practice. On the contrary, many still think it the best possible form of medical practice.

That's one reason why I believe that the failings they cite aren't inevitable, even in very large organizations. *Must* a group sacrifice medicine to business? *Must* it be run by and for self-seeking factions? I don't think so.

I haven't quoted the above criticisms in an effort to halt the trend toward bigger clinics. I've merely meant to point out that bigger clinics aren't necessarily better ones. They can offer improved services to patients and doctors alike only if their leaders keep one fact constantly in mind:

Medicine is our only business; and any overemphasis on business is poor medicine. END

And That's Serious

The foreign patient had limited English. When her husband visited her a few days after surgery, he found her in tears. She told him she was to be operated on again the next day.

He investigated. Seems she'd overheard her doctor tell the nurse, "Tomorrow we'll cut out her digalen."

—CATHRYN WEBER

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1. Meyer, J. H., et al., *A.M.A. Arch. Int. Med.* 96:330, 1955. 2. Meyer, J. H., et al., *South M. J.* 50:499, 1957. 3. Smith, F. H., and McQueen, E. G., *Lancet* 2:115, 1955. 4. Winston, S. S., *Internat. Rec. Med.* 170:465, 1957. 5. Matsumoto, W., et al., *J. Am. J. Psychiat.* 114:193, 1957.

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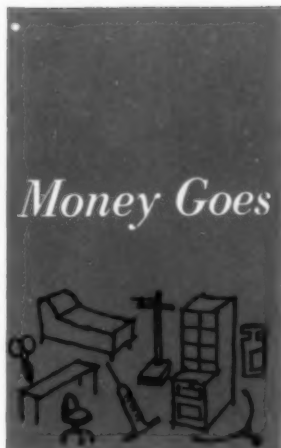
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How to Explain Where the

Do you sometimes find yourself talking with patients about your office overhead? Take a tip from this man's technique for explaining it

BY ALTON S. COLE



The internist's reception room was deserted, except for three visitors—two of them being a detail man and a rather irritable old gentleman. "This doctor," the old man was saying, "what a cinch *he's* got! He talks with me for ten minutes, he scribbles out a prescription, and bingo—it's \$5 in his pocket for professional services rendered."

"Five dollars in his pocket," the detail man repeated slowly. He paused, then said more sharply: "Listen, Mister, do you know where that money really goes?"

The old man didn't say anything, so the detail man went on: "I'll tell you where that \$5 goes. Two dollars of it goes

congestive

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BECKER, M. C., Simon, F. and Bernstein, A.: J. Newark Beth Israel Hosp. 9:58 (January) 1958.

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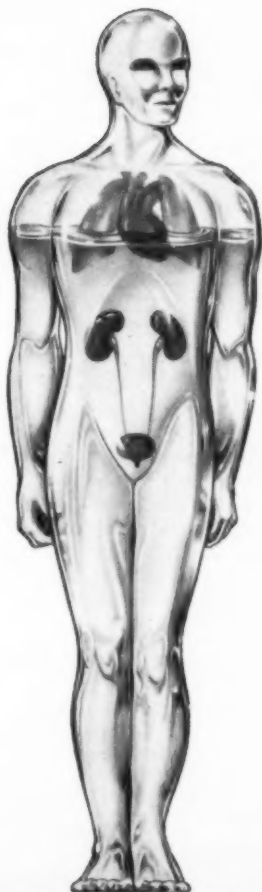
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WHERE THE MONEY GOES

just for maintaining this office. Another dollar of it goes to the Government in taxes. That leaves the doctor with the magnificent sum of \$2, free and clear, for doing something it took him eight years to learn how to do. You call that a cinch?"

The patient seemed startled into silence. He remained silent when the nurse poked her head through the door and beckoned to him. But he had a curiously thoughtful expression on his face as he disappeared from view.

The detail man turned to the other visitor and said: "They call it medical economics, you know. They say it's a multibillion-dollar business. Well, I've found people understand it better if you tell them where their \$3 or \$4 or \$5 goes. It's all true—and so sadly misunderstood."

I learned something useful from that little vignette. Perhaps you will, too.

END

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- ...the superior decongestant and antihistaminic action of Triaminic
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- ...an expectorant to augment demulcent fluids
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To reduce upper respiratory congestion and irritating secretions.

For non-narcotic control of the cough reflex.

To augment demulcent respiratory secretions.

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MEDICAL ECONOMICS • OCTOBER 27, 1958 193

New Depreciation Rules: Their Meaning for You

Continued from 72

tion. So if you want to get the most out of the depreciation speed-up, it may pay you to sell your old equipment in a separate transaction. Then, in a strictly cash deal, you can use the money toward the purchase of a replacement.

Suppose you've always depreciated your professional car over a four-year period. Can you now write it off over six years in order to cash in on the first-year allowance?

So far, there's no definite answer to this question. Cars used for professional purposes are usually written off in three to five years. By early autumn, the Internal Revenue Service hadn't yet said whether the period can now be stretched to six years. But it may well question any such new departure on tax returns for 1958.

At any rate, you'd gain little or nothing by lengthening the depreciation period for your car. Here's why:

Let's say you bought a \$4,000 professional auto last spring and

planned to depreciate it over four years on the declining-balance method. On that basis, you could write off half the car's cost—\$2,000—in the first year. At the end of four years you'd have it all charged off, down to the estimated salvage value.

Now, what would happen if you tried to depreciate it over six years so as to take advantage of the new law?

Well, you *could* deduct the special 20 per cent (\$800) for the first year. But your declining-balance depreciation on the remaining \$3,200 of the car's value would be only \$1,067 for the first of six years. Thus you'd get a total first-year deduction of \$1,867.

That's \$133 *less* than you can claim by the old method. And it would take you six years to write the car off instead of four.

So I'd state it as a general rule that if the estimated useful life of any item is less than six years, you'll gain little by trying to lengthen the period because of the new law. In some cases, there might be a slight advantage to the 20 per cent first-year allowance. But why risk a run-in with the I.R.S. merely for the sake of a slight advantage? **MORE▶**

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27	28	29	30	31						

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24	25	26	27	28	29	30			

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- relieves anxiety, irritability and fear
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NEW DEPRECIATION RULES

Under what circumstances should you use the new depreciation method?

It depends on your present income and future prospects. If you think your income will stay level or perhaps drop off in the next few years, you'll do well to claim the big first-year allowance for all equipment with an estimated useful life of six or more years.

As I've said, no matter which depreciation method you use, your total deductions over the years will be the same. But if you're like most doctors, you'd

rather write an item off just as fast as you can. The bigger the deductions you can claim now, the sooner you get the money back for your own use.

But if you expect to be earning a lot more money in the years to come, you'll probably be better off without the 20 per cent allowance. By forgoing a big write-off now, you push some good-size deductions off into the future when your income and tax rates will be higher. For doctors with growing practices, the old straight-line method is often still the best.

END

Satisfied with the usual cough remedies?



- do you find that the local soothing effect of cough syrups is not enough?
- are you concerned about the side effects of codeine?
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1. Shane, S. J., Krzyski, T. K., and Copp, S. E.: *Canad. M.A.J.* 77:600 (Sept. 15) 1957.

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What's a Reasonable Fee?

Continued from 98

any given case, all of them are likely to be considered.

As we've seen in the Campa-nella suit, though, some one of the criteria may prove the truly deciding factor. For example, the outcome may revolve around the question: What was the nature of the case? To illustrate:

Some years ago, a noted ophthalmologist was testifying in a New York courtroom. A wealthy layman who was present suffered a sudden heart attack.

The specialist rushed to give the man artificial respiration. After twenty minutes, it became clear that his efforts were of no avail. The man had died.

He Fought for It

Soon afterward, the ophthal-mologist submitted a \$500 bill to the patient's executors. They balked at its size. So he sued.

In court, another doctor testi-fied that the ophthalmologist was highly skilled and well justified in charging \$500 for his services. But physicians who testified for the estate pointed out that the

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WHAT'S A REASONABLE FEE?

nature of the case was such that the specialist's skill could hardly be a weighty consideration. They maintained that, since any medical student could have given artificial respiration with equal competence, a reasonable fee would be from \$10 to \$15.

A Lost Cause

Their testimony carried the day. The ophthalmologist was awarded \$15 instead of the \$500 he'd asked.

The moral of the story is plain: Before filing suit for nonpayment—or, for that matter, before

setting a fee in the first place—the wise doctor always asks himself whether the fee is in keeping with the procedure performed.

He also asks whether the fee is commensurate with his training and experience. In another interesting case, a young doctor first lost the decision, then won on appeal. As you read the following account, you'll note that both the original verdict and the reversal revolved around this question of training and experience. Here's what happened:

For nearly a month, a young orthopedist treated an elderly

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woman for possible spasmodic torticollis. Although he managed to ease her discomfort, he finally decided to call in a well-known neurologist. The neurologist treated the woman for some weeks. Then the two doctors referred the case to a brain surgeon.

What They Charged

Two operations proved unsuccessful. The woman died, leaving a sizable estate. The neurologist submitted a bill for \$1,875 and was paid. The brain surgeon submitted a bill for

\$1,250; he also was paid. But the executors turned down a \$1,500 bill from the orthopedist on the ground that it was excessive.

Experience Counts

When he sued, the court ruled against him. Since he was young and relatively inexperienced, it said, he could reasonably ask only \$262 for the services he'd rendered. Besides, it added, he wasn't entitled to a specialist's fee because he'd treated a neurological case, which was outside his specialty.

The M.D. appealed. MORE ►

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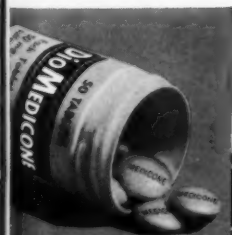
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WHAT'S A REASONABLE FEE?

And a higher court approved his original fee of \$1,500. Its reasoning:

Accent on Youth

Because a young physician is more apt to be abreast of recent medical developments, he may sometimes be more competent than older practitioners. And since neither disease nor cause of death had been firmly established in this case, it couldn't be proved that the orthopedist had practiced outside his specialty.

In using the fourth criterion for judging the reasonableness

of a medical fee—what's the doctor's professional standing?—the courts often study the physician's annual income and his customary charges. For instance, the judge who presided over the Campanella case ordered Dr. Shenkman to produce his income tax returns for several past years. The neurosurgeon was also required to state the largest fee he had charged in the past.

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Failure to produce such evidence as proof of high standing once helped cost a California



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G.P. a \$12,000 fee. The case involved the late W. C. Fields, the strawberry-nosed motion-picture actor.

Fields was 56 and at the height of his career at the time he was treated. He was under contract for three different movies at the rate of \$100,000 each, and he had some \$700,000 in the bank.

A Long Short Snort

But he was in horrifying physical shape. He had both polyneuritis and Paget's disease. And it was also reported, over his characteristically vigorous

denials, that he regularly downed between one and two quarts of whisky a day.

So, when he got bronchopneumonia, the G.P. who was his personal physician advised immediate hospitalization. Fields agreed—but only on condition that the doctor would accompany him to the hospital and stay there with him.

The physician complied. For twenty-three days and nights, he lived in a hospital room adjoining Fields'. He left the hospital only at rare intervals in order to get changes of clothing and to

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WHAT'S A REASONABLE FEE?

find a sanitarium where Fields could go when no longer bed-ridden.

For the long period of constant attendance, the doctor eventually billed the actor for \$12,000. Fields refused to pay. So the G.P. sued him and won.

Why the Doctor Failed

The decision only got Fields' Irish up. He appealed, and a higher court reversed the verdict. Among its reasons: Because the trial judge had upheld an objection from the G.P.'s attorney, the doctor had stated neither his in-

come for recent years nor his customary charges. Explained the court:

"The professional standing of [the physician] was one of the elements properly to be considered in determining the reasonable value of the services rendered. The earnings of [the physician] and his customary charges were also proper subjects of inquiry to aid in determining his professional standing and the reasonable value of the services rendered . . . The sustaining of the objection was prejudicial error." END

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it's
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For the elderly patient who lacks appetite, is all worn out—too tired to eat—prescribe the high potency combination of B₁₂ and B₁:

TROPHITE* *for appetite*

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PHONE CALL MEMO

TIME: 9:15 a.m.

TO: Dr. Leeds

CALLED BY: Mr. Neuman

MESSAGE: Called to say he's feeling much better but the intense itching rash has returned on his arms and legs. I recommended Calmitol and arranged an appointment for tomorrow morning.

A.T.

Thanks. Calmitol is one of the safest antipruritics we know and should relieve Mr. Neuman until I can see him. S.L.

*Calmitol is the non-sensitizing antipruritic supplied as Ointment in 1½-oz. tubes and 1-lb. jars, and as Liquid, for more stubborn pruritus, in 2-oz. bottles by Thos. Leeming & Co., Inc., New York 17, N.Y.

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q. 12 h.



Two capsules on arising **last all day**
Two capsules at bedtime **last all night**
relieve nervous tension on a *sustained*
basis, without between-dose interruption.

*"The administration of meprobamate in
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Dosage: 2 Meprospan capsules q. 12 h.
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1. Meprobamate is more widely prescribed than any
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2. Baird, H. W., III: A comparison of Meprospan
(sustained action meprobamate capsule) with other
tranquilizing and relaxing agents in children.
Submitted for publication, 1958.

Literature and samples on request

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who discovered and introduced Miltown®

Memo

From the Editors

Coming in November

"MEDICAL ECONOMICS?" said George Meany, president of the A.F.L.-C.I.O., when introduced to a roving editor of this magazine. "I didn't know doctors *had* any economic problems."

"Well, they do," retorted a physician who was standing nearby. "And they've also got labor problems!"

This good-humored exchange is reported in the next issue of MEDICAL ECONOMICS. And if George Meany really doubted that doctors had problems, he'd learn something by scanning this magazine in November.

Some sample quotes:

Dr. Samuel B. Hadden on the problem of labor health centers: "It's quite possible you can put a silver dollar in a machine and back your rear end up to the machine and get an injection . . . Perhaps you can treat some *diseases* on a production line. But you can't treat sick *people* on a production line . . . Sick people want individual treat-

ment on a free-choice basis . . ."

Dr. Joseph Kris on the problem of setting fees for unusual services: "Sure, that bill of mine [\$1,500 for saving a boy's life] got a tremendous amount of bad publicity. But it was the publicity that was bad, not the bill. I set the fee after consultation with my colleagues, including medical society officers. They thought it was entirely reasonable—until the headlines and the higher-ups in medicine made them back down on professional principles . . ."

Dr. Anthony J. J. Rourke on the problem of medical mistakes: "Not long ago, as I remember it, most doctors would rather have lost an arm than admit a mistake . . . Now, as a result of our hospital accreditation program, medicine has become the only profession whose members sit together formally to analyze one another's failures and successes . . . Accreditation has done more for American medicine than any other recent development—even antibiotics . . ."

Why this much emphasis on people and problems? Because the right combination of the two often leads to *solutions*.

You'll find many such combinations in the pages of MEDICAL ECONOMICS' Nov. 10 and Nov. 24 issues.

END